UEC Diagnostic

Summary of findings and implementation approach

Why transform urgent and intermediate care in Dorset?

The performance of UEC and the outcomes we achieve for people have not recovered to pre-COVID levels.

Our dedicated staff, volunteers and carers provide excellent care every day to thousands of people, but sometimes, the system gets in the way and can cause harm.

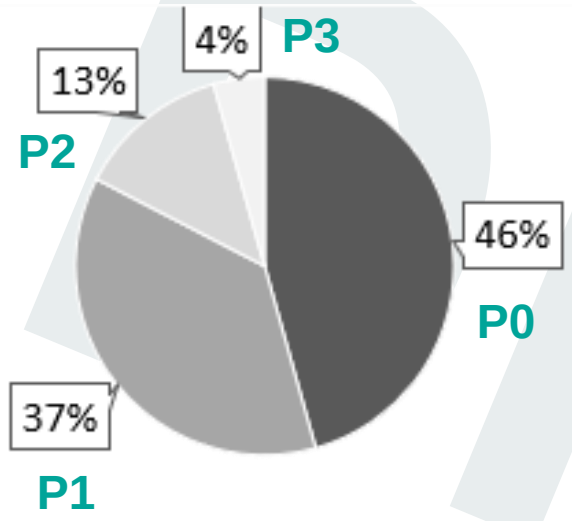
The pathways and services have evolved to create a complex system for people and staff to navigate and can prevent us achieving the best outcomes:

- **Too many people spend more time in hospital than they need to**
- **Our short-term care in the community is provided across many different services with too many handoffs**
- **We have a high use of bed-based care with varying levels of support**
- **Many older people could reduce or avoid the deconditioning that has an impact on their independence and long-term care needs**

The complexity and scale of the issues require a true system approach to improve and transform outcomes for individuals. It is proposed a system-level transformation programme is undertaken to achieve these improved outcomes and deliver essential financial benefits.

Voice of the Person

Voice of the Person



46 Interviews completed

50% Spoke positively about the System

Headlines:

There's a fair bit of negativity about communication across communication of **next steps, involvement in decision-making and bringing the person's wider circle into discussions**.

> *I could have been told what care package was in place, for how long and at what cost. I knew nothing.*

> *Niece not aware of discharge, when patient got home chaos for 24 hours.*

> *Was told six weeks [of care], got two.*

What's the pulse within your organisation/teams?

Nancy's Story

Nancy lived at home, independently, with informal support from her sons, John and Stuart.

One Saturday morning, Nancy's son, John, visited her house and found Nancy suffering from breathlessness and a runny nose. As Nancy's local GP was closed due to the weekend, John phoned 111 and was advised to phone 999 so that paramedics could assess Nancy in her home. Services such as UCR and Virtual Wards weren't considered by 111.

Worrying that waiting for the ambulance was a waste of resources as he was able to transport Nancy, John chose to drive Nancy to hospital. John wasn't made aware during his interactions with 111 and 999 that there were services available in the community to diagnose and treat Nancy at home.

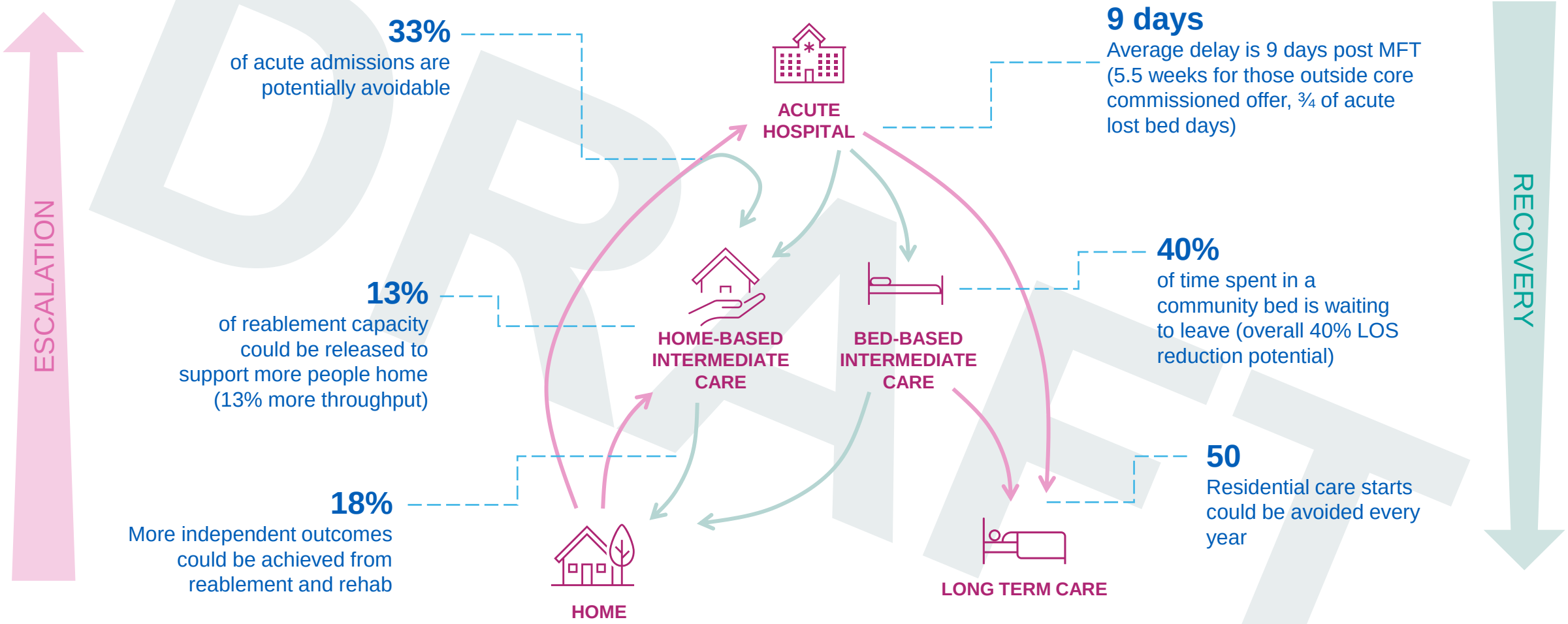
Nancy was assessed in ED and even though it was decided that only a period of observation and a prescription of antibiotics was required, ED chose to admit Nancy onto a specialty ward. Services such as Virtual Wards/AHAH and SDEC were not consulted about whether Nancy would be suitable for referral.

Nancy was deemed medically fit for discharge after 7 days and returned home.

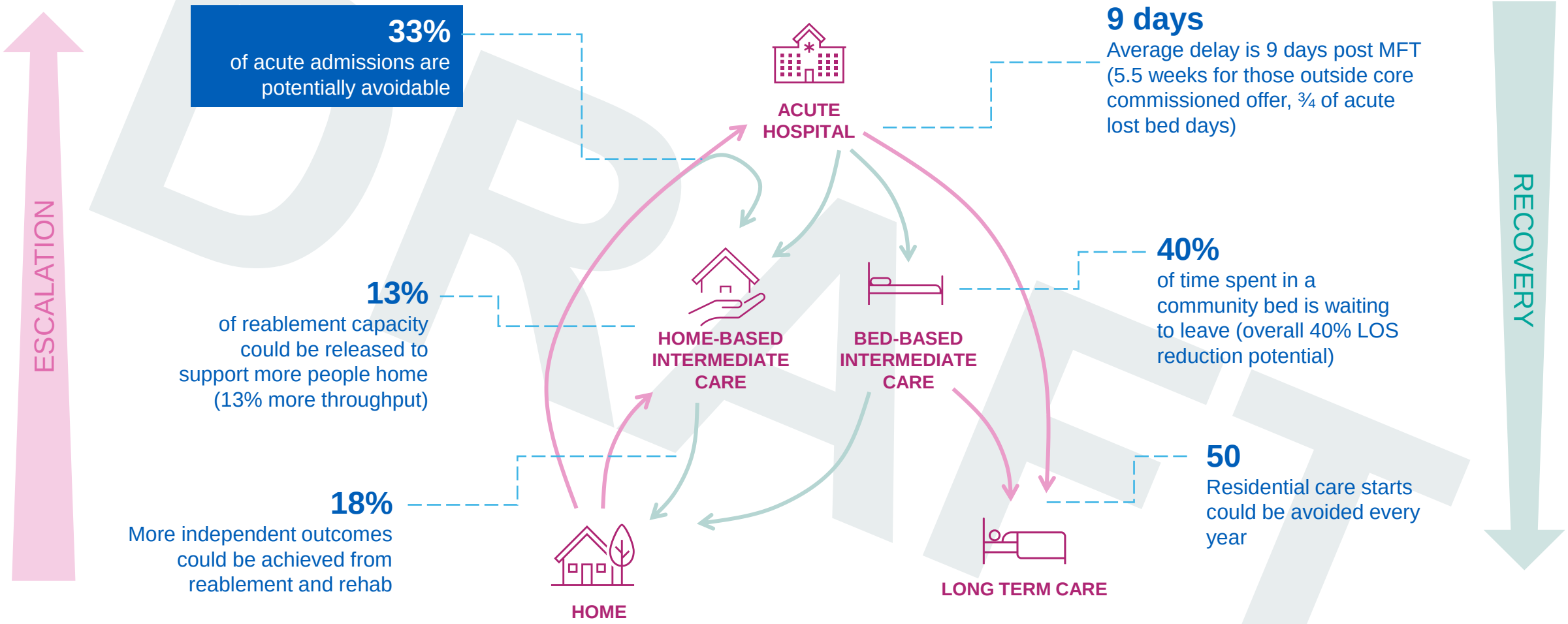
> **This lady could have been turned around before even reaching A&E and instead she's had a week-long stay in hospital**
>
> – Consultant Practitioner during case reviews

Diagnostic Findings

The evidence shows an opportunity to improve outcomes for people, and to support financial sustainability, that we can't ignore

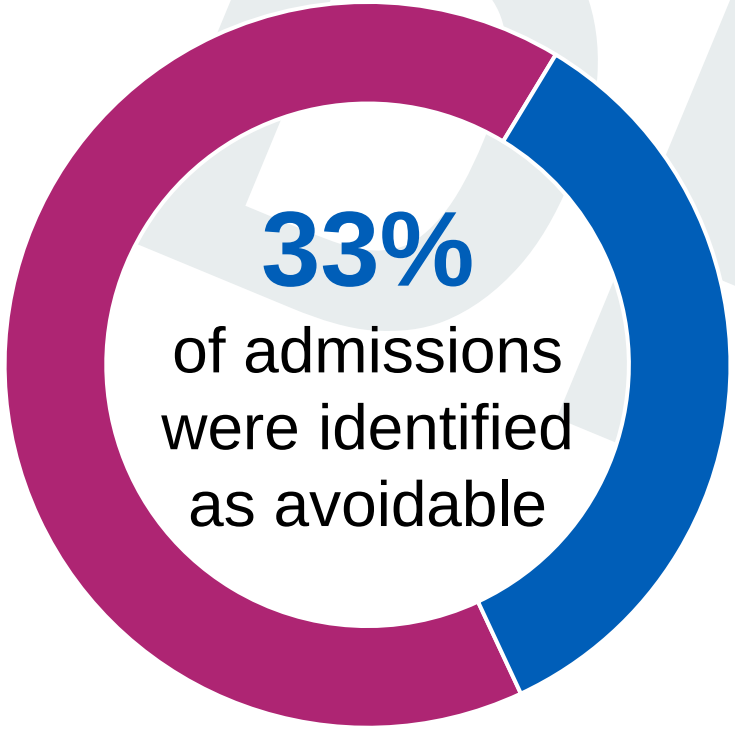


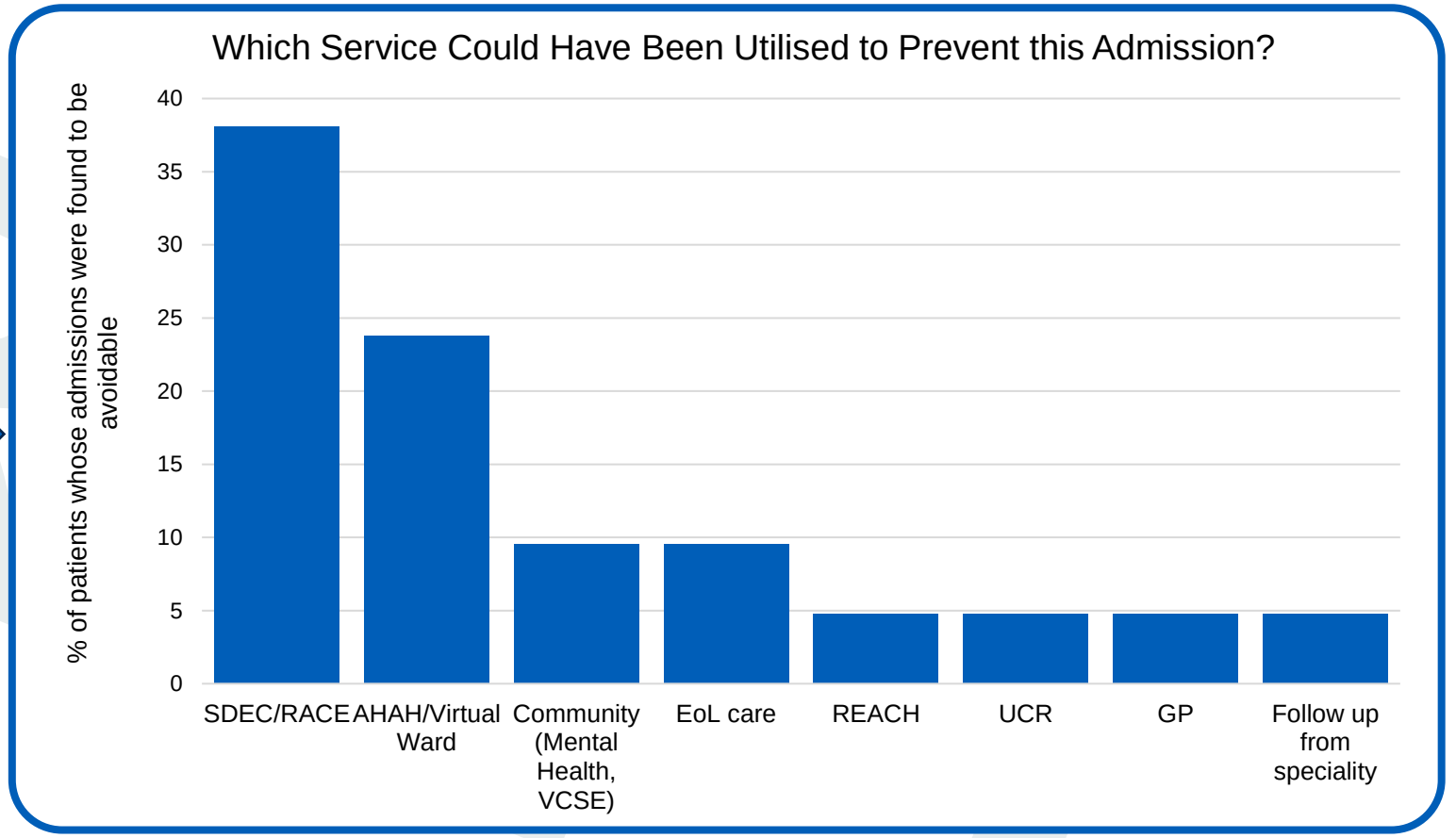
The evidence shows an opportunity to improve outcomes for people, and to support financial sustainability, that we can't ignore



1/3 of admissions onto specialty wards from ED were found to be avoidable after reviewing the patient journey

For each avoidable admission, the MDT were then asked; *"Which service or services could have been used to prevent this admission?"*



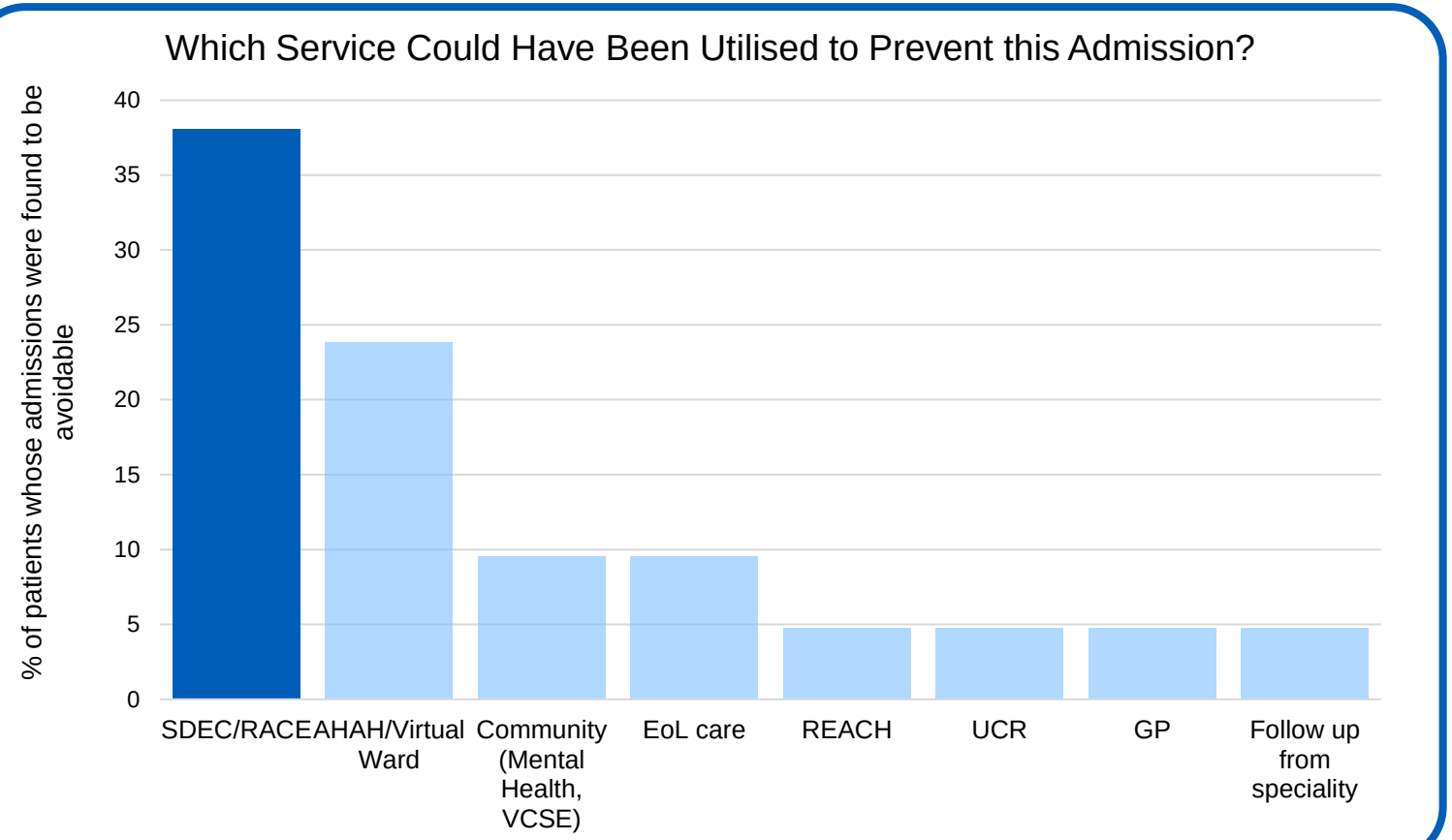


Same Day Units and **Step-Up Services** were identified as the main levers to enable reduced admissions

38% of avoidable admissions across the system could have been routed through SDEC

Why was SDEC not utilised?

- SDEC unable to take patient (out-of-hours)
- Lack of capacity in SDEC
- Risk-averse decision making



> *"**Identifying patients in ED** who are SDEC suitable **as early as possible** is where the big wins will be found"*
>
> – SDEC Consultant

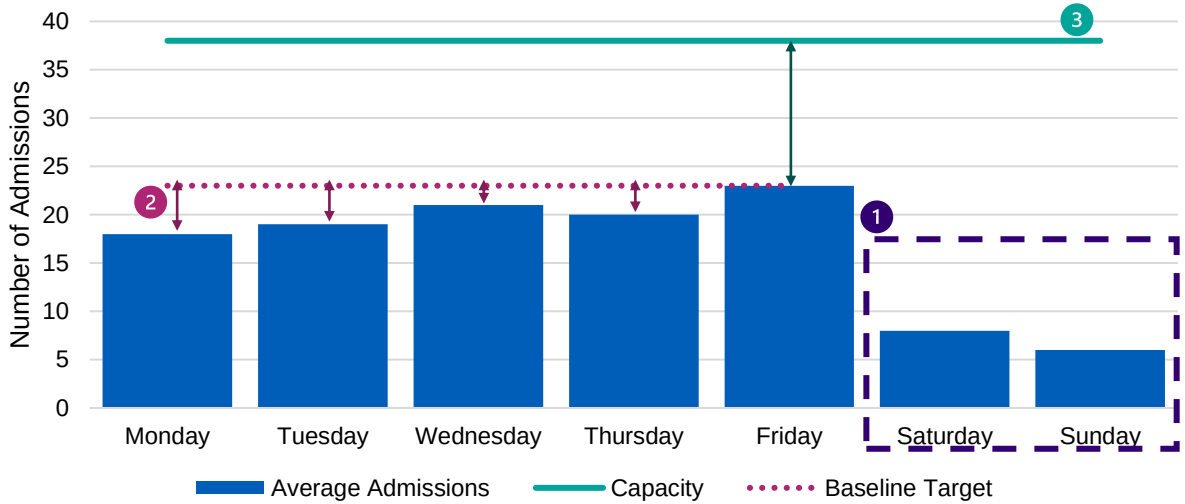
38% of avoidable admissions across the system could have been routed through SDEC

Why was SDEC not utilised?

SDEC unable to take patient (out-of-hours)

Lack of capacity in SDEC

Risk-averse decision making

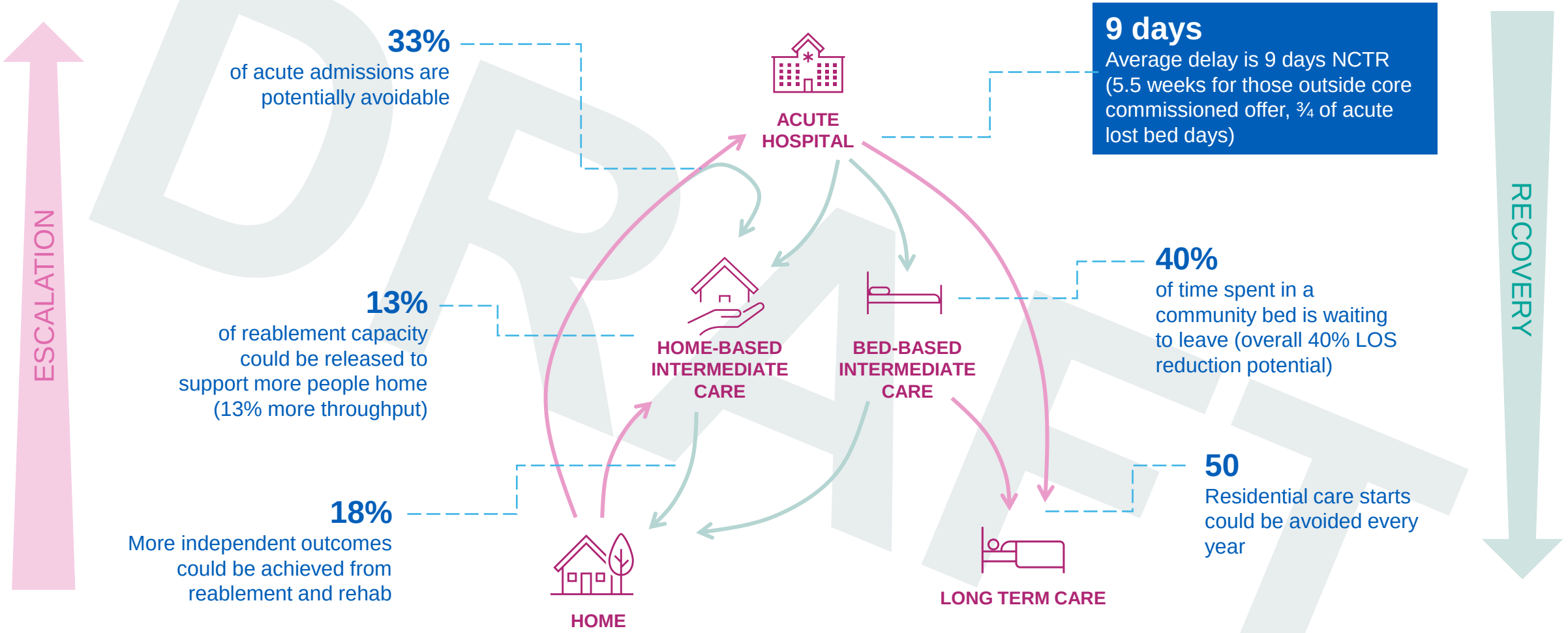


1 **Weekend capacity:** DCH SDEC currently sees an average of 20 patients on weekdays but only 7 patients on weekends.

2 **Daily variation:** Removing this variation between days would allow over 500 admissions to be avoided per year

3 **Increase capacity to match demand:** Analysis identified potential further demand for 5 patients per day - DCH has achieved the capacity for more than this on certain days, showing that meeting this demand is possible

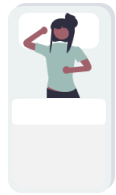
The evidence shows an opportunity to improve outcomes for people, and to support financial sustainability, that we can't ignore



Delays to discharge are multi-faceted, and system-wide

Treatment (CTR)	**30%** of the time deciding and arranging the ongoing support	**28%** of the time is spend waiting for Social work processes	**23%** is spent waiting for the capacity in onward services

Patients wait in hospital while ongoing support is arranged, but the process is difficult, referrals get rejected, patients get stuck.



We could plan for discharge sooner to prevent avoidable delays later.

Too many people are assessed in hospital and leads to overprescription of bedded care.

Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations.

We spend a lot of time tracking and discussing our most complex patients but sometimes they still take weeks to be discharged.

The capacity in community services is not well matched to demand so people end up waiting longer for availability of the service.

Delays to discharge are multi-faceted, and system-wide

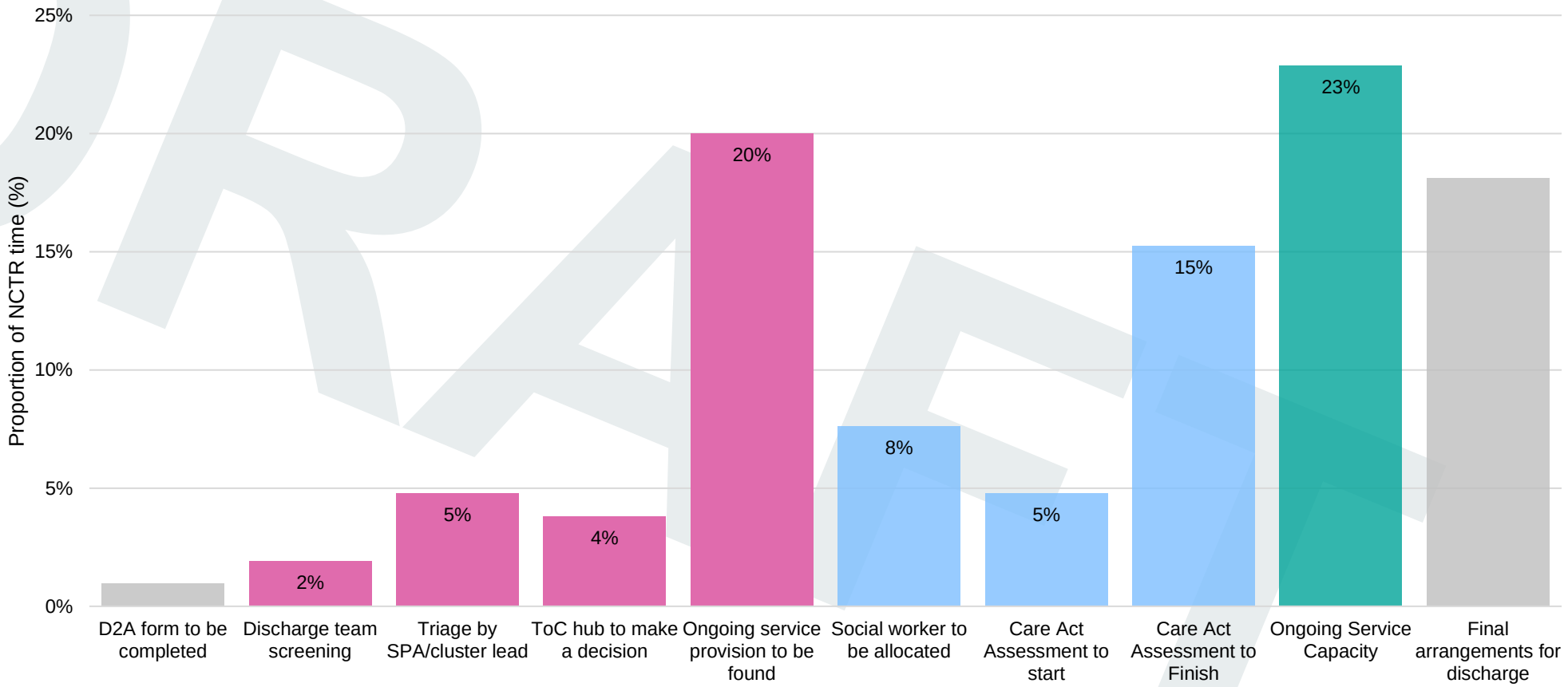
Treatment (CTR)

30% of the time deciding and arranging the ongoing support

28% of the time is spend waiting for Social work processes

23% is spent waiting for the capacity in onward services

Studies were conducted at all 3 acute hospitals to understand how long patients spend at each stage of the discharge process. Snapshots were taken over 2 to 3 days, **looking at over 300 patients with no criteria to reside** across a number of wards. Discharge notes were used to record at which stage of the process each patient was at.



Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations

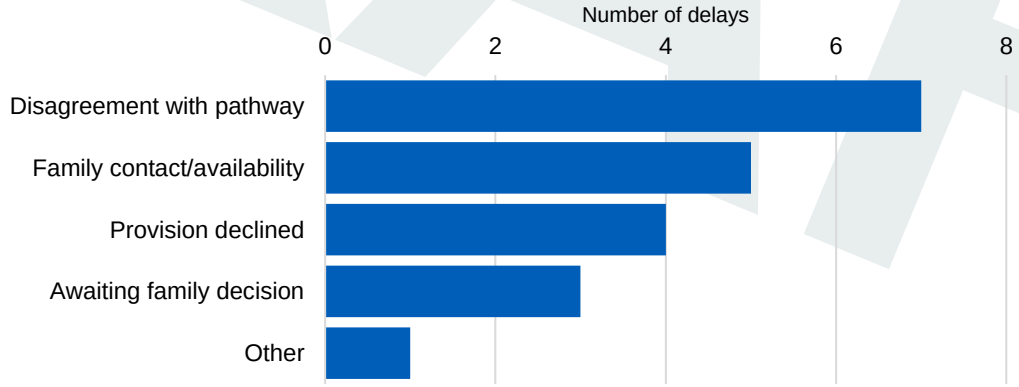
Treatment (CTR)	**30%** of the time deciding and arranging the ongoing support	**28%** of the time is spend waiting for Social work processes	**23%** is spent waiting for the capacity in onward services

We could plan for discharge sooner to prevent avoidable delays later.

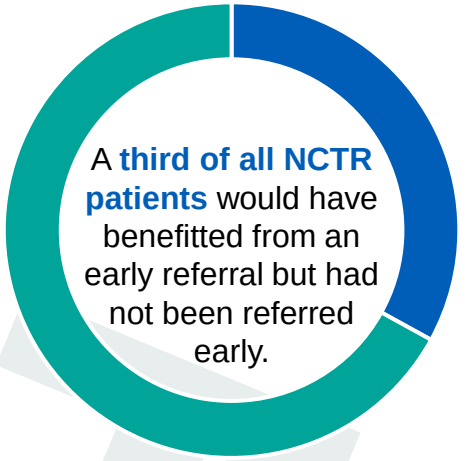
Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations.

D2A case reviews found that **family/friends wishes** was the underlying reason behind **17% of non-ideal length of stays** and **18% of non-ideal outcomes**

The studies found that **9% of post-NCTR discharge process time is spent resolving patient and family wishes** and looked in more depth at the reasons.



Would earlier planning help?



Of the 63 NCTR patients surveyed in UHD

"ToC needs to be a collective responsibility. It's owned by the discharge team and we pull on people when needed. Until a patient hits the SPA list [only once medically ready and D2A submitted] it isn't collective." ***Discharge Lead, DCH***

Our TOC process is improving but is contributing to avoidable delays

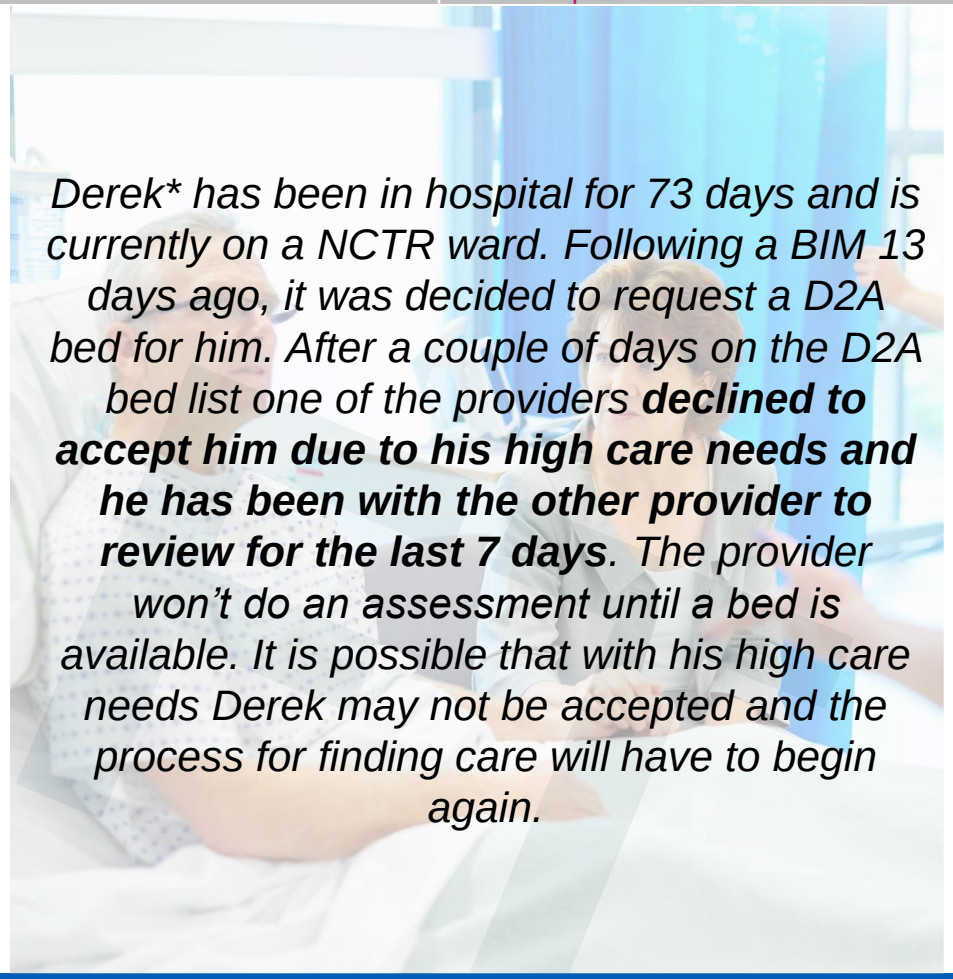
Treatment (CTR)	**30%** of the time deciding and arranging the ongoing support	**28%** of the time is spend waiting for Social work processes	**23%** is spent waiting for the capacity in onward services

Patients wait in hospital while ongoing support is arranged, but the process is difficult, referrals get rejected, patients get stuck.

We could plan for discharge sooner to prevent avoidable delays later.

Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations.

We spend a lot of time tracking and discussing our most complex patients but sometimes they still spend weeks to be discharged.

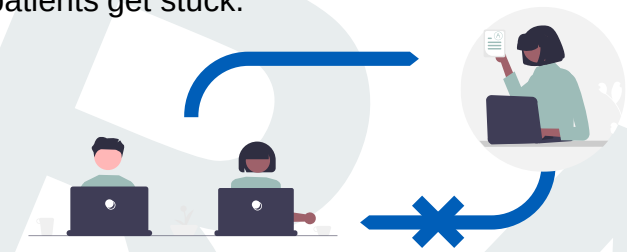


Derek has been in hospital for 73 days and is currently on a NCTR ward. Following a BIM 13 days ago, it was decided to request a D2A bed for him. After a couple of days on the D2A bed list one of the providers **declined to accept him due to his high care needs and he has been with the other provider to review for the last 7 days**. The provider won't do an assessment until a bed is available. It is possible that with his high care needs Derek may not be accepted and the process for finding care will have to begin again.*

Our TOC process is improving but is contributing to avoidable delays

Treatment (CTR)	**30%** of the time deciding and arranging the ongoing support	**28%** of the time is spend waiting for Social work processes	**23%** is spent waiting for the capacity in onward services

Patients wait in hospital while ongoing support is arranged, but the process is difficult, referrals get rejected, patients get stuck.



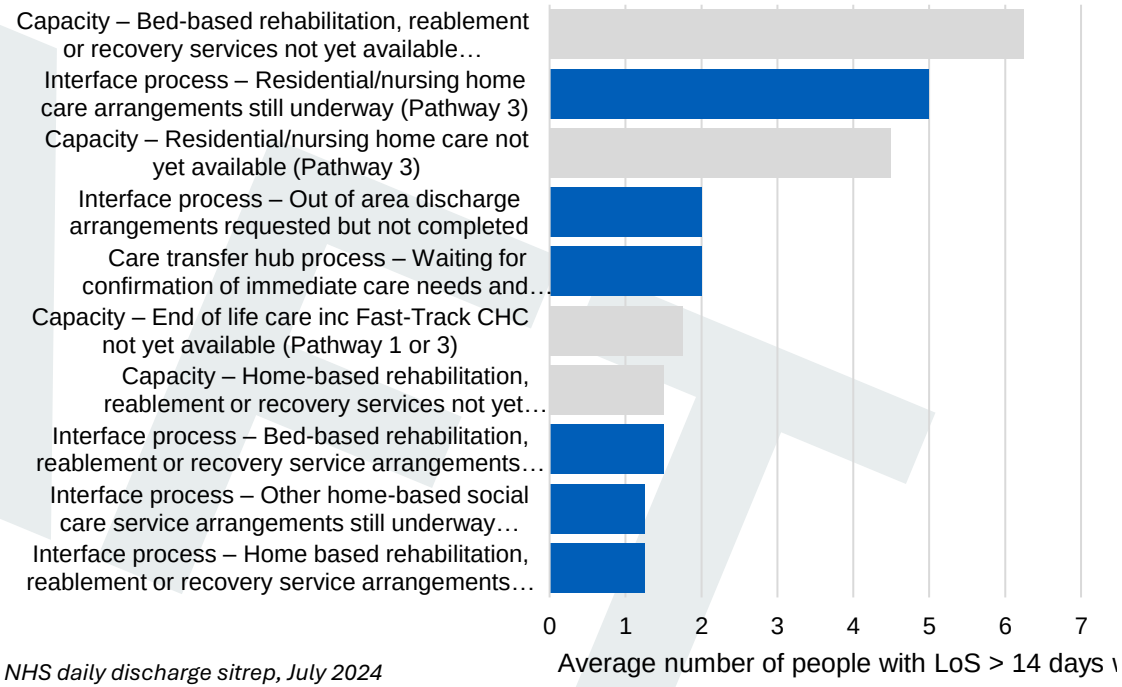
We could plan for discharge sooner to prevent avoidable delays later.

Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations.

We spend a lot of time tracking and discussing our most complex patients but sometimes they still spend weeks to be discharged.

In DCH, approximately **50% of delays are caused by processes around organising care**

Top 10 delay reasons (14 days and over) DCH



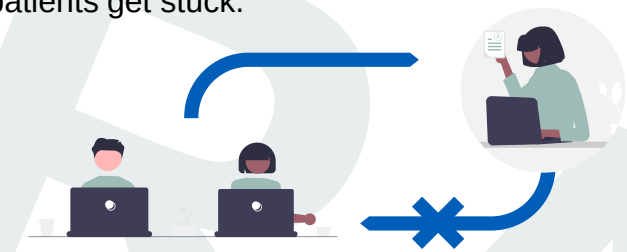
Source: NHS daily discharge sitrep, July 2024

Weekly snapshot average of the total number of people per day with length of stay 14 days or over who no longer meet the criteria to reside but were not discharged, broken down by the reasons why they continued to reside

Our TOC process is improving but is contributing to avoidable delays

Treatment (CTR)	**30%** of the time deciding and arranging the ongoing support	**28%** of the time is spend waiting for Social work processes	**23%** is spent waiting for the capacity in onward services

Patients wait in hospital while ongoing support is arranged, but the process is difficult, referrals get rejected, patients get stuck.



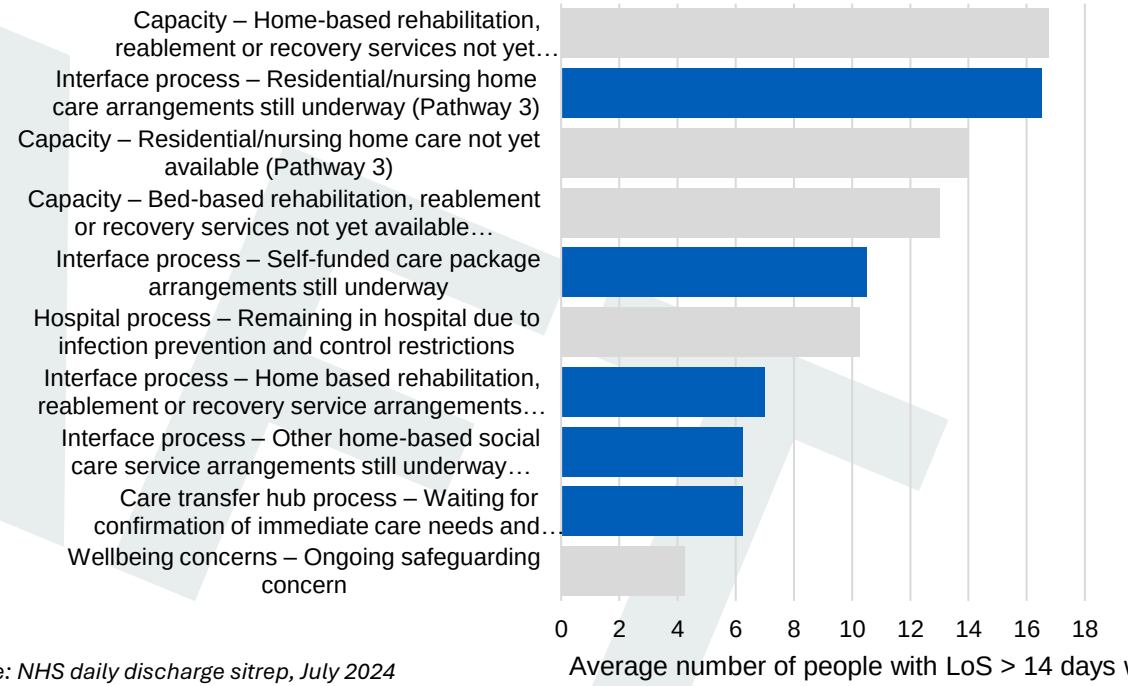
We could plan for discharge sooner to prevent avoidable delays later.

Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations.

We spend a lot of time tracking and discussing our most complex patients but sometimes they still spend weeks to be discharged.

At UHD, approximately **45% of delays are caused by processes around organising care**

Top 10 delay reasons (14 days and over) UHD



Source: NHS daily discharge sitrep, July 2024
Weekly snapshot average of the total number of people per day with length of stay 14 days or over who no longer meet the criteria to reside but were not discharged, broken down by the reasons why they continued to reside

Some of our patients spend multiple weeks waiting for discharge

Treatment (CTR)	30%	of the time deciding and arranging the ongoing support	28%	of the time is spend waiting for Social work processes	23%	is spent waiting for the capacity in onward services

Many Care Act Assessments are taking place in hospital. This is happening for 'non-core' pathway 1 and pathway 2 patients, whose needs can't be met by the commissioned P1 services.

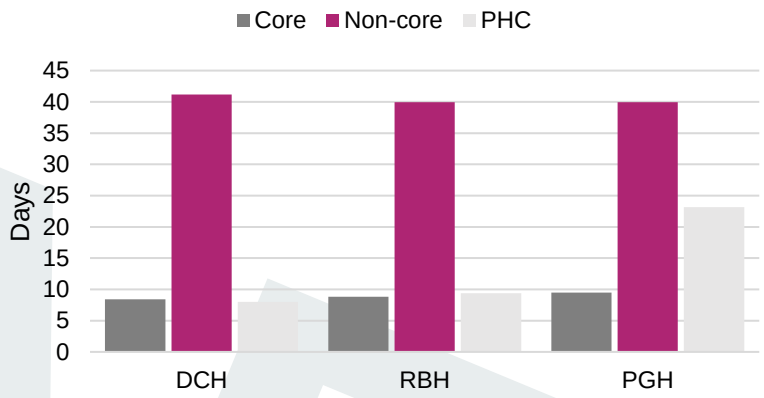
28% of time spent in social work processes is just waiting for allocation, and Care Act Assessments take multiple weeks to complete.

"It's a real shock to me how long people have to stay in the hospital. As a practice educator previously, I didn't realise how many people are delayed." **Ward clinical lead, UHD**

Patients wait in hospital while ongoing support is arranged, but the process is difficult, referrals get rejected, patients get stuck.

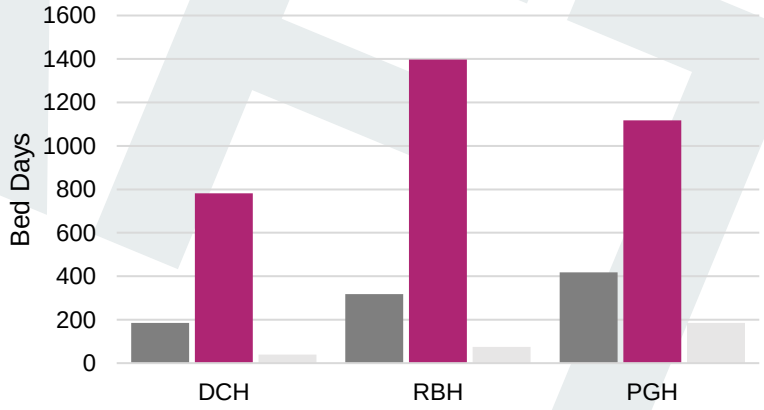
We spend a lot of time tracking and discussing our most complex patients but sometimes they still spend weeks to be discharged.

AVERAGE DELAY PER PATIENT



Patients who fall outside the criteria of our core services will wait in hospital for **five and a half weeks**.

TOTAL DELAY BED DAYS



These patients also make up **nearly three-quarters** of the acute lost bed days across county but is only **40%** of our NCTR patients. (73%)

Some of our patients spend multiple weeks waiting for discharge

Treatment (CTR)	30%	of the time deciding and arranging the ongoing support	28%	of the time is spend waiting for Social work processes	23%	is spent waiting for the capacity in onward services

Patients wait in hospital while ongoing support is arranged, but the process is difficult, referrals get rejected, patients get stuck.

We could plan for discharge sooner to prevent avoidable delays later.

Opportunities are missed to discuss discharge plans with families and carers early to avoid mis-aligned expectations.

We spend a lot of time tracking and discussing our most complex patients but sometimes they still spend weeks to be discharged.

"We have had three patients on our ward die in hospital due to a long length of stay. ***One of them, who could have gone out the same day and only needed a temporary placement****, had longer delays as she wasn't in the social work system and died after 100 days in hospital.* ***Another would have been appropriate to go home with a QDS core package but this wasn't possible due to capacity****. Whilst waiting he deteriorated due to the long length of stay, suffering 18 falls in hospital. After an 89 day length of stay he died from covid."*

Ward sister, UHD

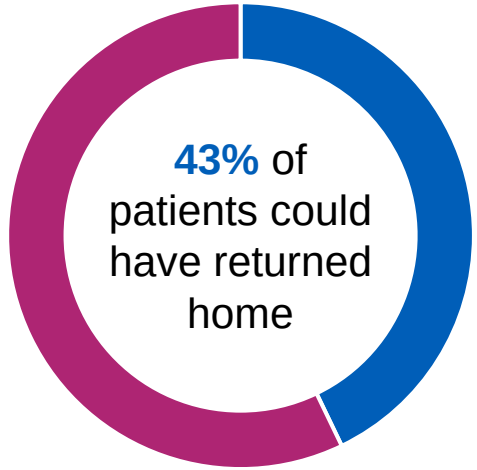
The D2A assessment found that **57% of patients could have left hospital sooner**

Patients are missing the opportunity to be assessed out of hospital and too many people are ending up in 24h care instead of getting home.

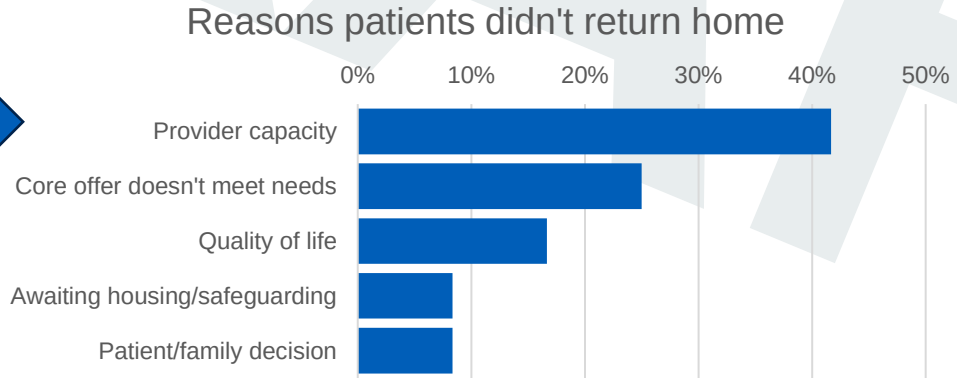
Treatment (CTR)	30%	of the time deciding and arranging the ongoing support	28%	of the time is spend waiting for Social work processes	23%	is spent waiting for the capacity in onward services	Onward pathway decision

The D2A assessment found that **38% of people on P2 were discharged on a non-ideal pathway**.

To further validate, we asked of people in P2 settings “Could this person have returned home?”



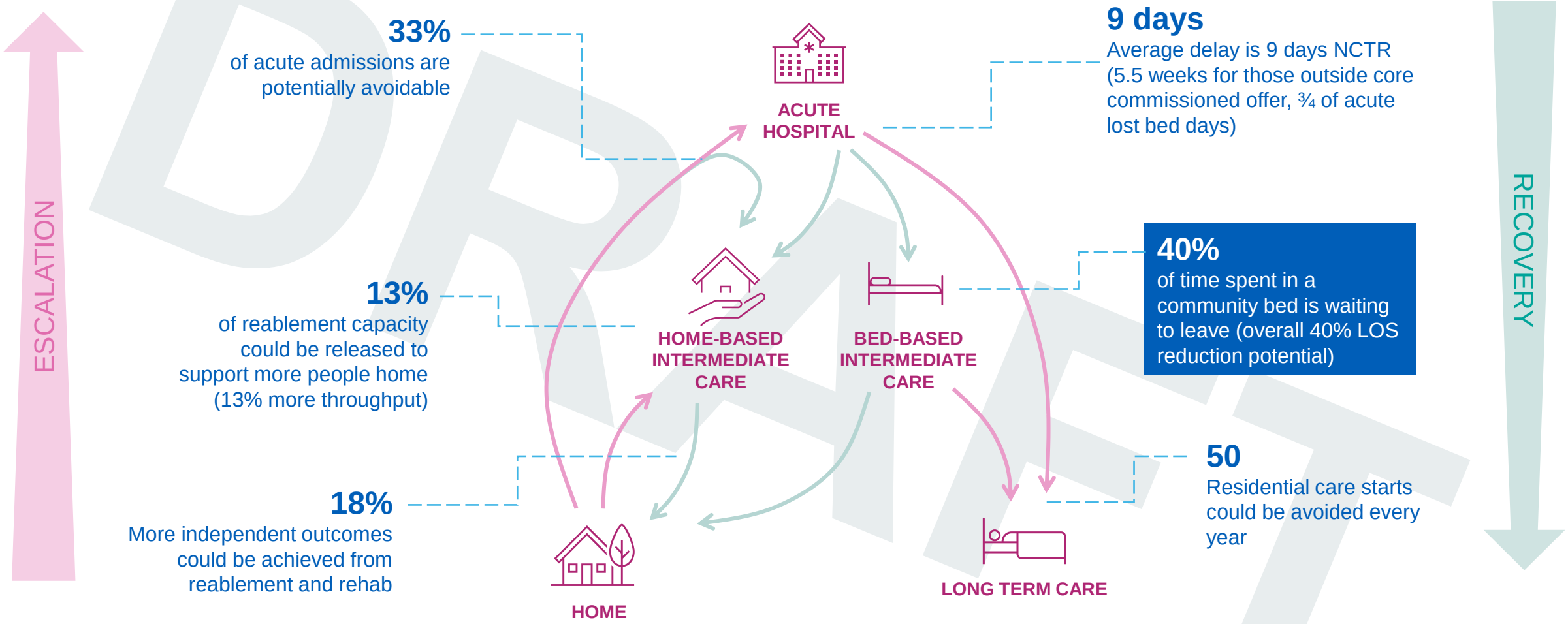
Too many people are assessed in hospital and leads to overprescription of bedded care.



All of the patients that didn’t return home due to provider capacity were in Dorset reablement beds. These were being used to get patients out of hospital while awaiting a PoC

“If we had a big enough P1 offer, all the patients in community hospitals could go home. Probably 90% of them.” **Discharge and Flow Matron, Community Hospitals**

The evidence shows an opportunity to improve outcomes for people, and to support financial sustainability, that we can't ignore



Bed-based Intermediate Care supports people to go home

There are **4 different types of community beds** available across Dorset:

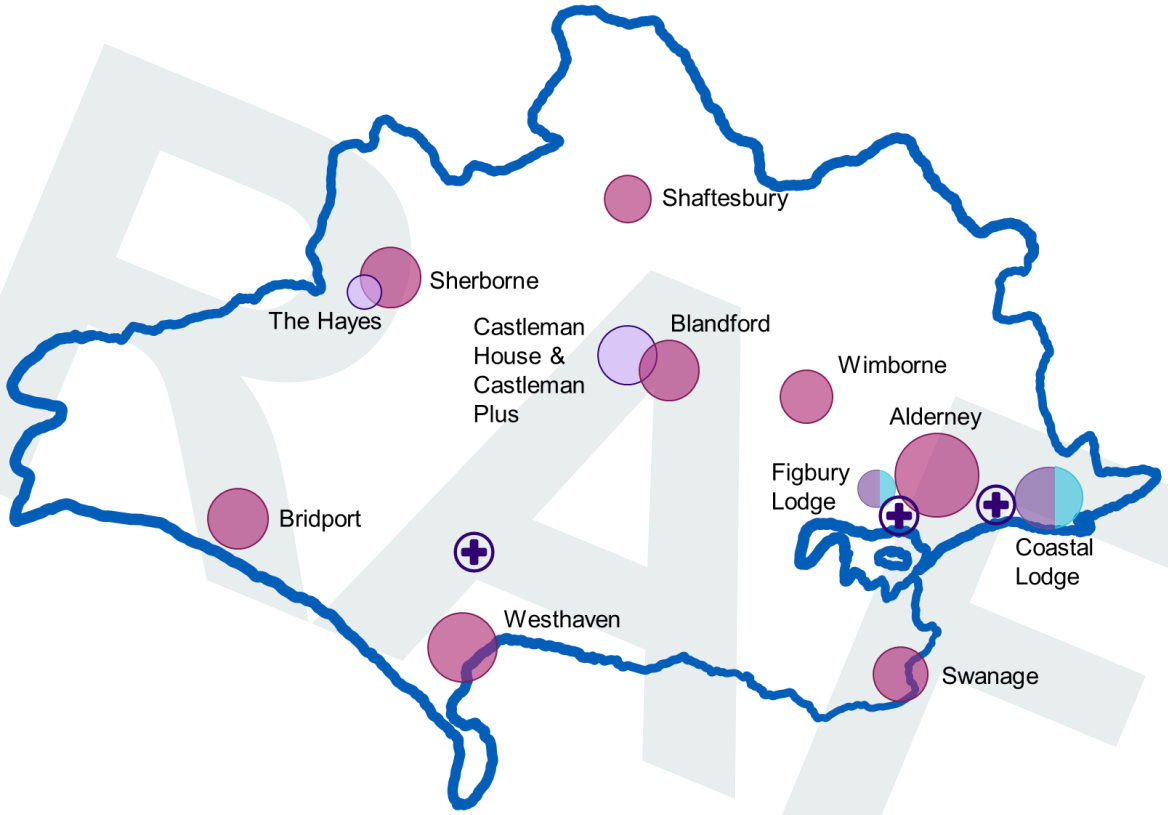
Community hospitals **208**

Therapy input on-site where we can also access sub-acute care

38

BCP D2A Beds
(Therapy off site)

Beds for patients requiring further rehab or assessment, have to request therapy input



BCP Rehab Beds **20**
(Therapy on site)

Therapy led sites that can accept a high complexity of patient

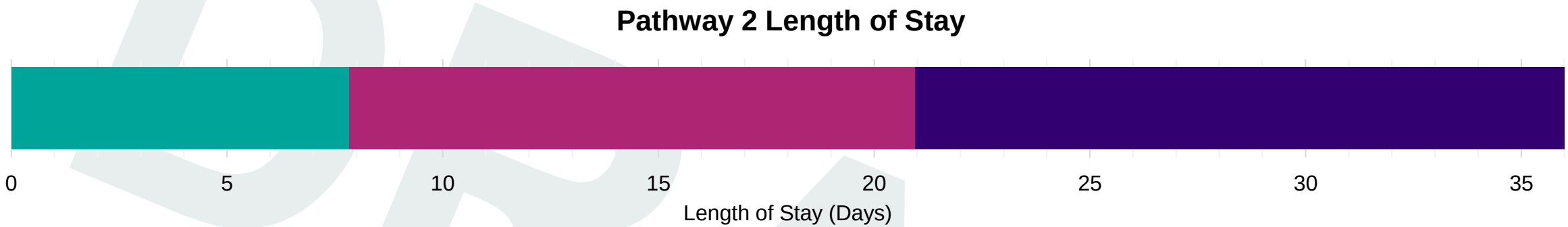
Dorset Council Reablement beds **30**

Beds for medically stable patients with low complexity, have to request therapy input

Dorset – 38 intermediate beds per 100,000 people
National average – 23 beds per 100,000 people

40% of a time in a community bed is spent waiting to be discharged, across all P2 beds

On average a patient spends 36 days in a community pathway 2 bed, which can be broken down to:



8 days

spent **Waiting for Therapy**

This includes those waiting to become medically or therapy fit to start their rehab or reablement

13 days

spent **Receiving Therapy**

These are spent actively receiving rehab or reablement to increase independence and allow the patient to return home

Is there an opportunity to optimise patients recovery time to allow them to go home sooner?

15 days

spent **Waiting to be discharged**

This time is after a patient has met all rehab goals for their P2 stay and can either go home to continue reablement or start a long term support package

Could this delay be reduced to get patients home as soon as possible?

*Data obtained from studies of 134 P2 beds across 9 sites

Jane’s journey through a P2 bed

Waiting for Therapy	Receiving Therapy	Waiting to be discharged

DAY 0

Jane has had a nasty fall whilst at home and has broken her hip. She has been to hospital and has been medically optimised for discharge. She has been referred to a P2 unit to work on quickly regaining some mobility so that she can go home and continue reablement to be able to live as independently as possible. Initially, **she is unable to begin therapy and must wait a week for her fracture clinic appointment.**

DAY 8

Jane has had her fracture clinic appointment and can now begin her therapy. The therapy team have set her a goal of being able to comfortably perform stand-sit tasks with the assistance of one person. This will enable her to continue her reablement at home. Her progress is regularly monitored throughout her time in recovery and Nurses regularly encourage her to move. **She makes good progress and should be able to leave soon!**

DAY 21

After 13 days of therapy, Jane now feels comfortable performing stand-sit tasks with the help of one and is ready for discharge out of a P2 bed. **The process of arranging her discharge begins** and the Discharge to Assess form is sent to Single Point of Access(SPA) to begin the process of determining and arranging her ongoing care needs. Her medication is arranged as well as any equipment required to make her home safe for her to return.

DAY 36

After waiting for 15 days, Jane can finally go home safely with the appropriate package of care. It was determined by SPA that Jane would need social work input as her care needs were complex. **Assigning her a social worker** accounted for a significant proportion of Jane’s time waiting for discharge in the P2 unit. Once she had been assigned a social worker and her care needs had been decided, she was **waiting for a care provider to have availability.**

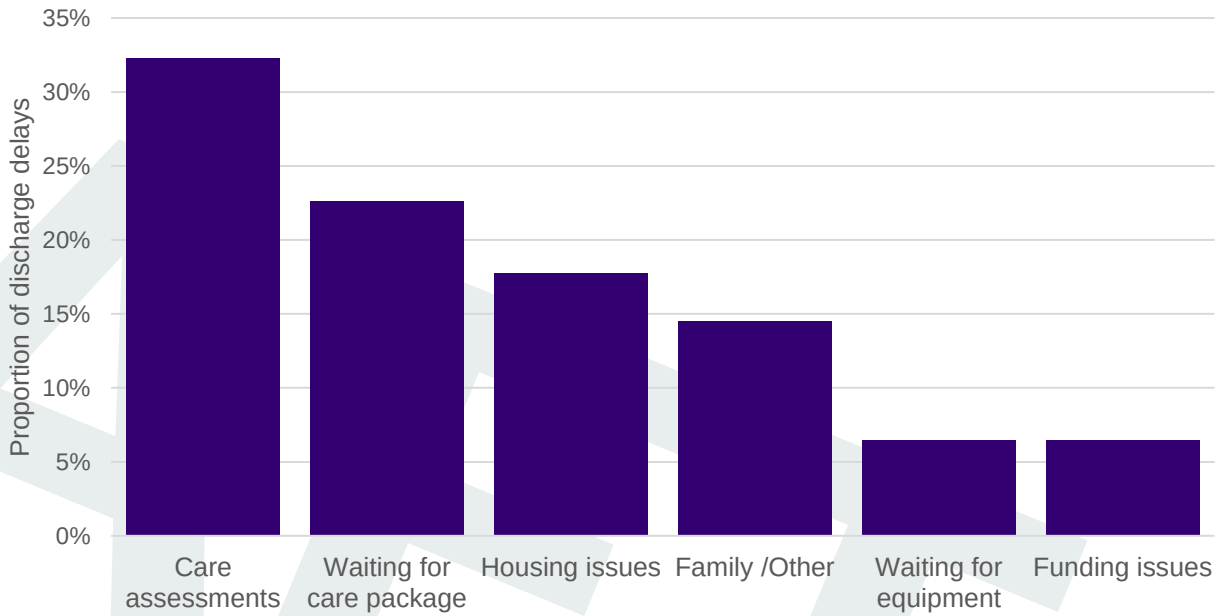
Could this delay be reduced to get patients home as soon as possible?

*Patient journey based on real patient stories from studies (Names and identifiable information have been removed)

Jane’s journey through a P2 bed

Waiting for Therapy	Receiving Therapy	Waiting to be discharged

A third of discharge delays days are due to waiting for social care assessments to be completed



Could this delay be reduced to get patients home as soon as possible?

*Patient journey based on real patient stories from studies (Names and identifiable information have been removed)

Jane’s journey through a P2 bed

Waiting for Therapy	Receiving Therapy	Waiting to be discharged

Social worker availability

Staff in P2 units across the system expressed frustration at being unable to get social workers assigned to patients in a reasonable amount of time. Getting a social worker assigned often took weeks and any existing social work input would often be paused until a referral from SPA had been received. If a social worker could have been assigned earlier, patients could have been discharged sooner.

“Patients can be waiting for a social worker for weeks!”

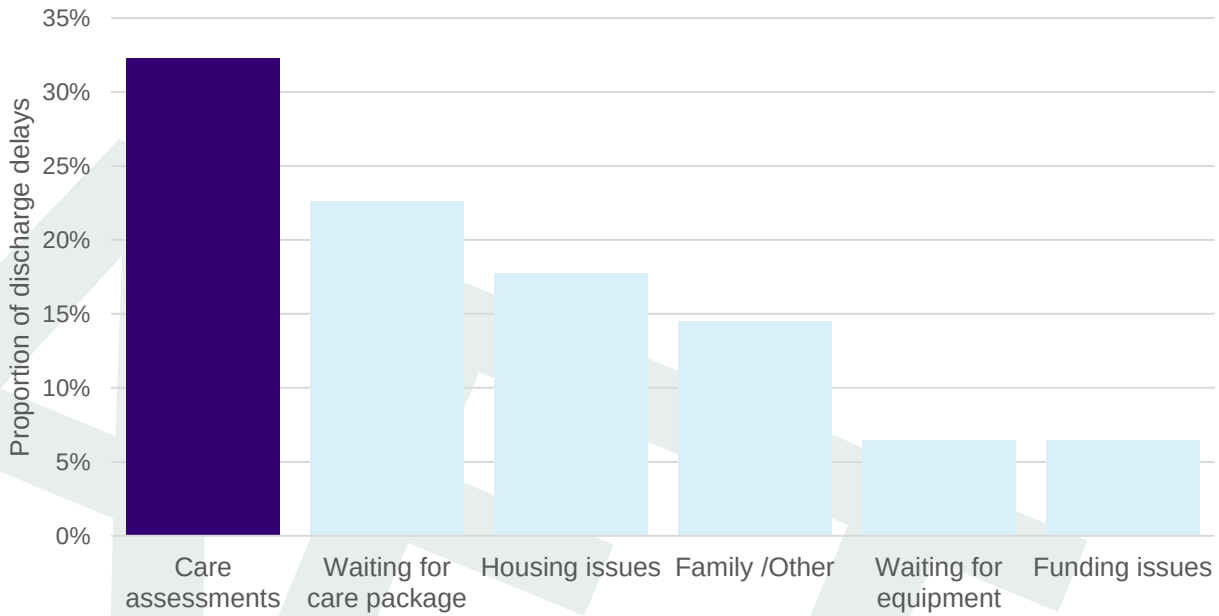
Nurse

Regular social worker input

Staff also expressed frustration that social workers were not regularly present at the units or at MDT meetings. This blocked an effective transfer of information, meaning that handovers took a long time. Staff also identified that it heightened other challenges around organising care which frequently came up, including housing and family issues for which medical professionals are not trained. More regular social worker input could have enabled patients to be discharged sooner.

“We used to have a social worker come in regularly and they really knew the system, but not anymore … we end up looking like idiots in front of the family!”

OT

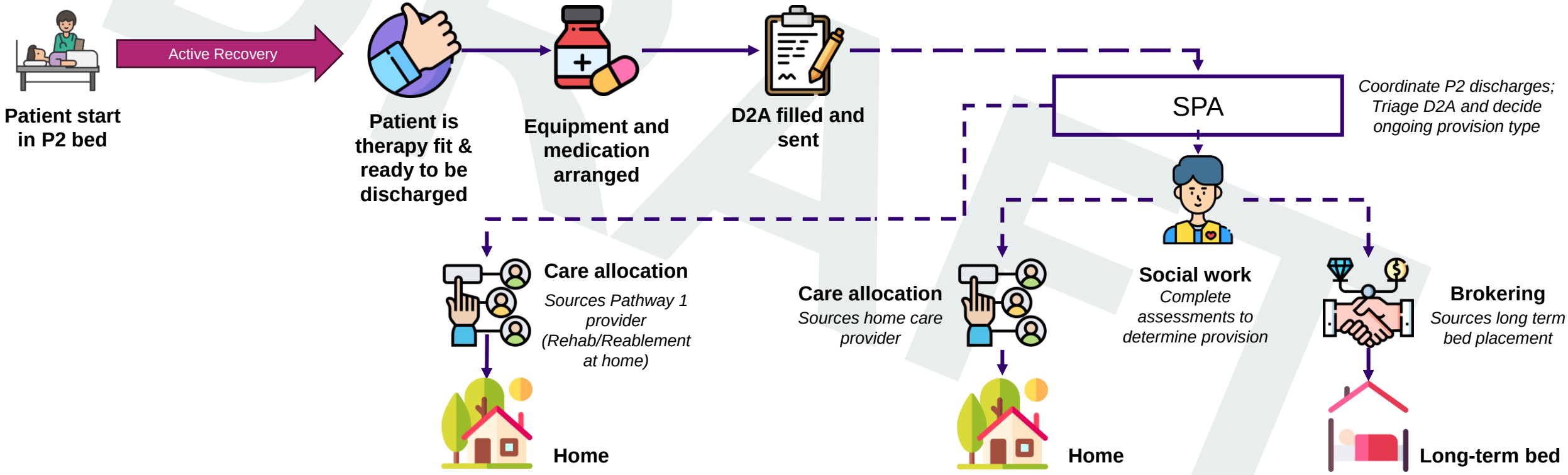


*Patient journey based on real patient stories from studies (Names and identifiable information have been removed)

There are 5 different teams or organisations that could be involved before a person is discharged

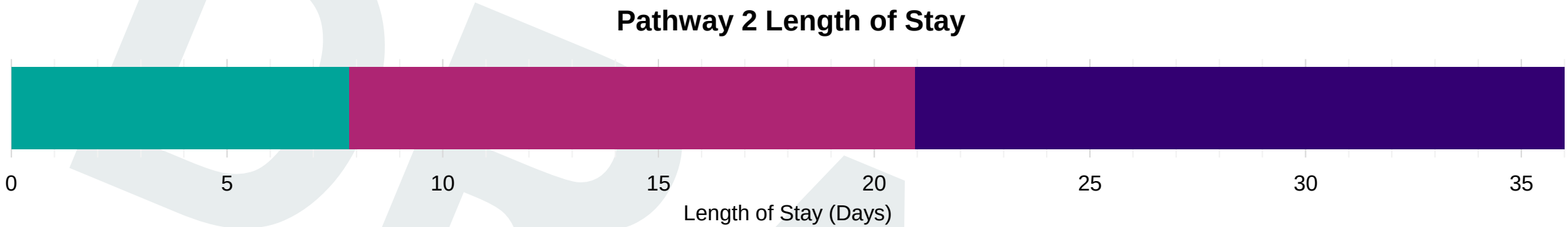
Waiting for Therapy	Receiving Therapy	Waiting to be discharged

The discharge process from community beds involves multiple handoffs between different organisations, which creates many opportunities for delays



40% of a patients time in a community bed is spent when they are fit to be discharged

On average a patient spends 36 days in a community pathway 2 bed, which can be broken down to:



8 days
spent **Waiting for Therapy**

This includes those waiting to become medically or therapy fit to start their rehab or reablement

13 days
spent **Receiving Therapy**

These are spent actively receiving rehab or reablement to increase independence and allow the patient to return home

15 days
spent **Waiting to be discharged**

This time is after a patient has met all rehab goals for their P2 stay and can either go home to continue reablement or start a long term support package

Is there an opportunity to optimise patients recovery time to allow them to go home sooner?

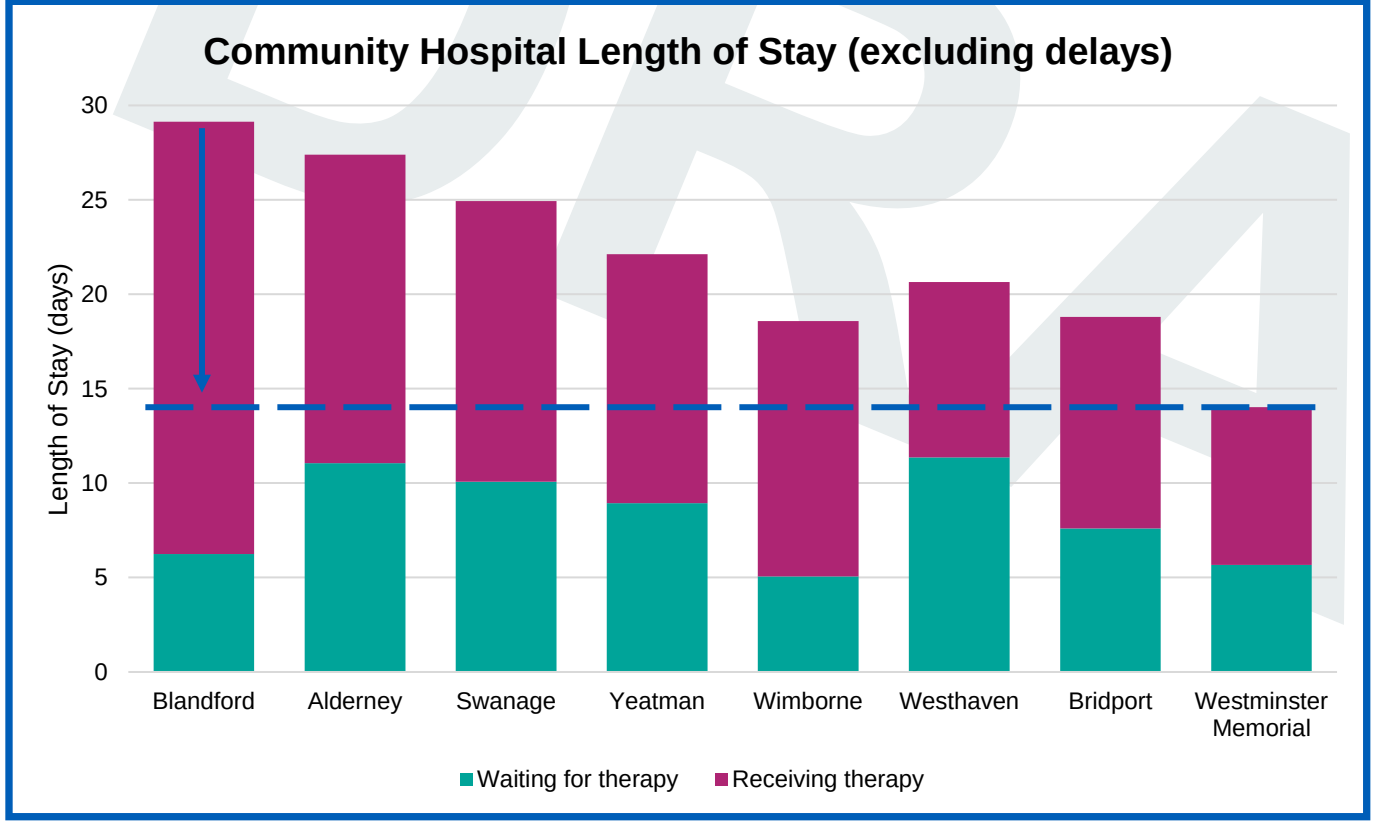
Could this delay be reduced to get patients home as soon as possible?

*Data obtained from studies of 134 P2 beds across 9 sites

There is variation in how long Active recovery takes

Waiting for Therapy	Receiving Therapy	Waiting to be discharged

Days taken for a patient to be ready for discharge varies significantly, even between community hospitals with similar cohorts of patients



Time taken for a patient to become therapy fit for discharge can be split into two stages:

Waiting for Therapy – waiting to be fit to start therapy

Receiving Therapy – actively receiving rehab or reablement to progress towards goals

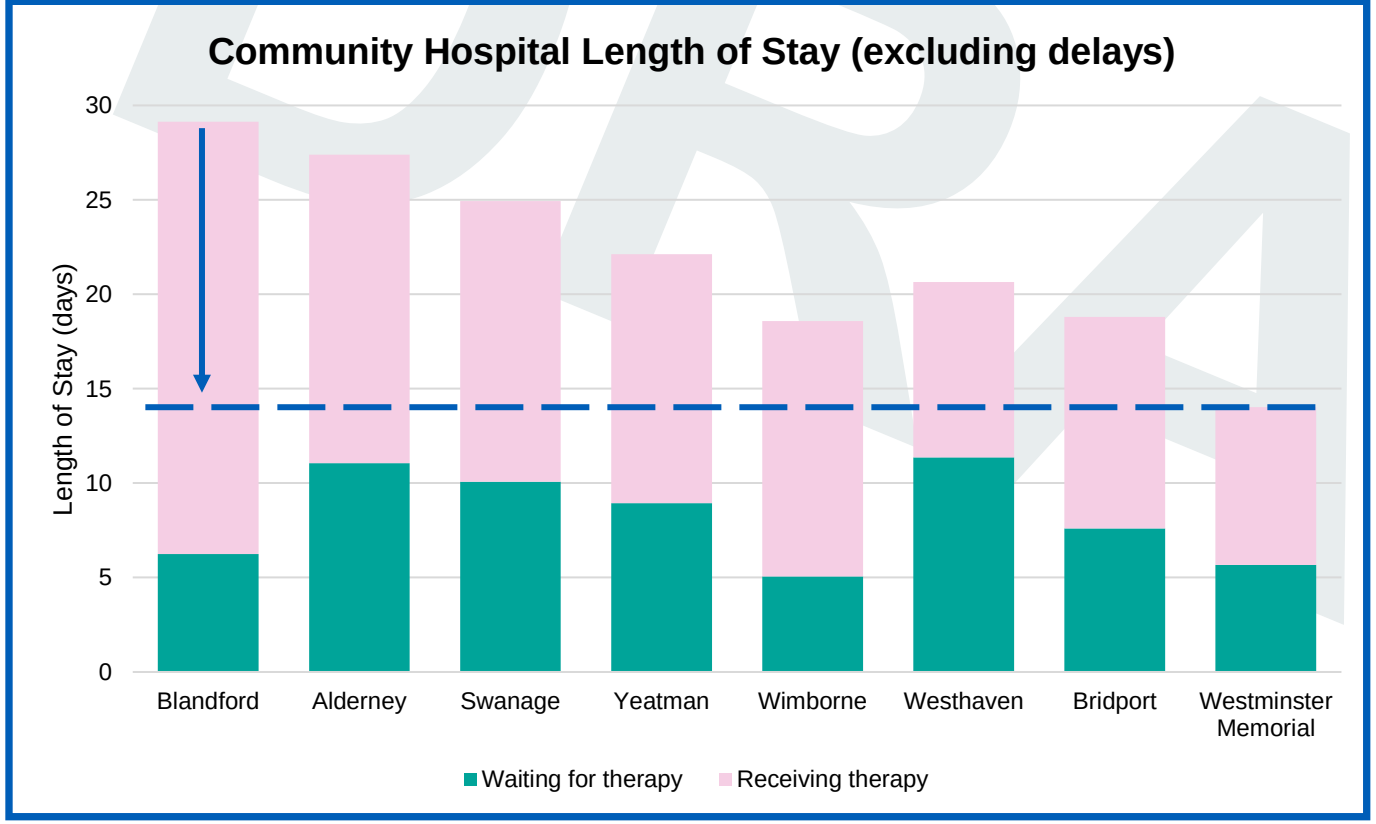
There are opportunities to reduce time spent in community hospitals in both of these stages

*Data from DHC BI + studies of 79 CoHo beds across 3 sites (average of delays taken for non-studied sites)

There is variation in how long Active recovery takes

Waiting for Therapy | Receiving Therapy | Waiting to be discharged

Days taken for a patient to be ready for discharge varies significantly, even between community hospitals with similar cohorts of patients



Waiting for Therapy

Time waiting for therapy accounts for 25% of LoS, and **over half** of this is due to patients who are non-weight bearing upon P2 admission. There are two key enablers to reducing this wait:

Right decisions on discharge

Differences in Pathway 2 beds mean that there is more access to specialist support to allow patients to begin their recovery sooner. Considering whether the patients needs require this support while referring to pathway 2 sites from the acute hospital can reduce the delay once the patient is in the community bed

Certain types of patients need certain specialist treatment

OT

Quality of referral information

Referrals to pathway 2 often contain a lack of detail or outdated information making it difficult to plan the support a patient needs in advance. When support such as fracture clinics is required this is only found out after the patient has been assessed in the pathway 2 bed, delaying their access to these services

9 out of 10 times we have to assess the patient from scratch

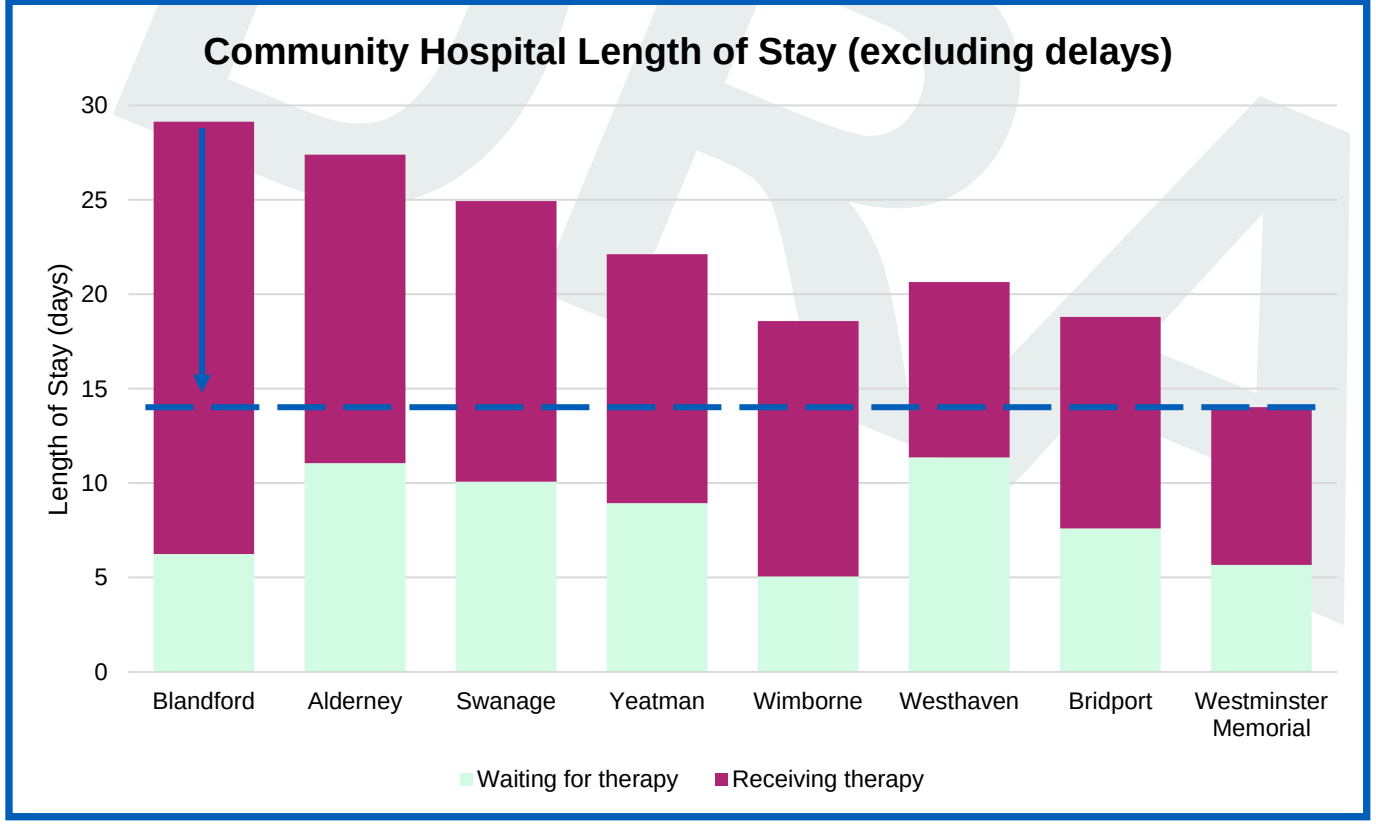
ACP

*Data from DHC BI + studies of 79 CoHo beds across 3 sites (average of delays taken for non-studied sites)

There is variation in how long Active recovery takes

Waiting for Therapy | Receiving Therapy | Waiting to be discharged

Days taken for a patient to be ready for discharge varies significantly, even between community hospitals with similar cohorts of patients



Receiving Therapy

Time spent receiving therapy varies significantly between community hospitals. This is a clinical or therapy led decision, although there can be improved consistency in:

Goal setting and progress tracking

Following Pathway 2 beds there is an opportunity for patients to continue their recovery at home – in the best examples P2 beds are used only to get patients to this point so that they can do most of their recovery at home. In multiple cases we are aiming to get people as far as possible within the P2 bed when they could receive some of this support at home.

We do as much as we can to make sure the patients are safe

Nurse

Expected discharge dates

Expected discharge dates (EDDs) can be used to effectively judge progress, with all parties able to target when a person will be ready to be discharged. They are most effective when set at the start of a persons stay based on the assessment of needs and can help proactive management of a persons Length of Stay

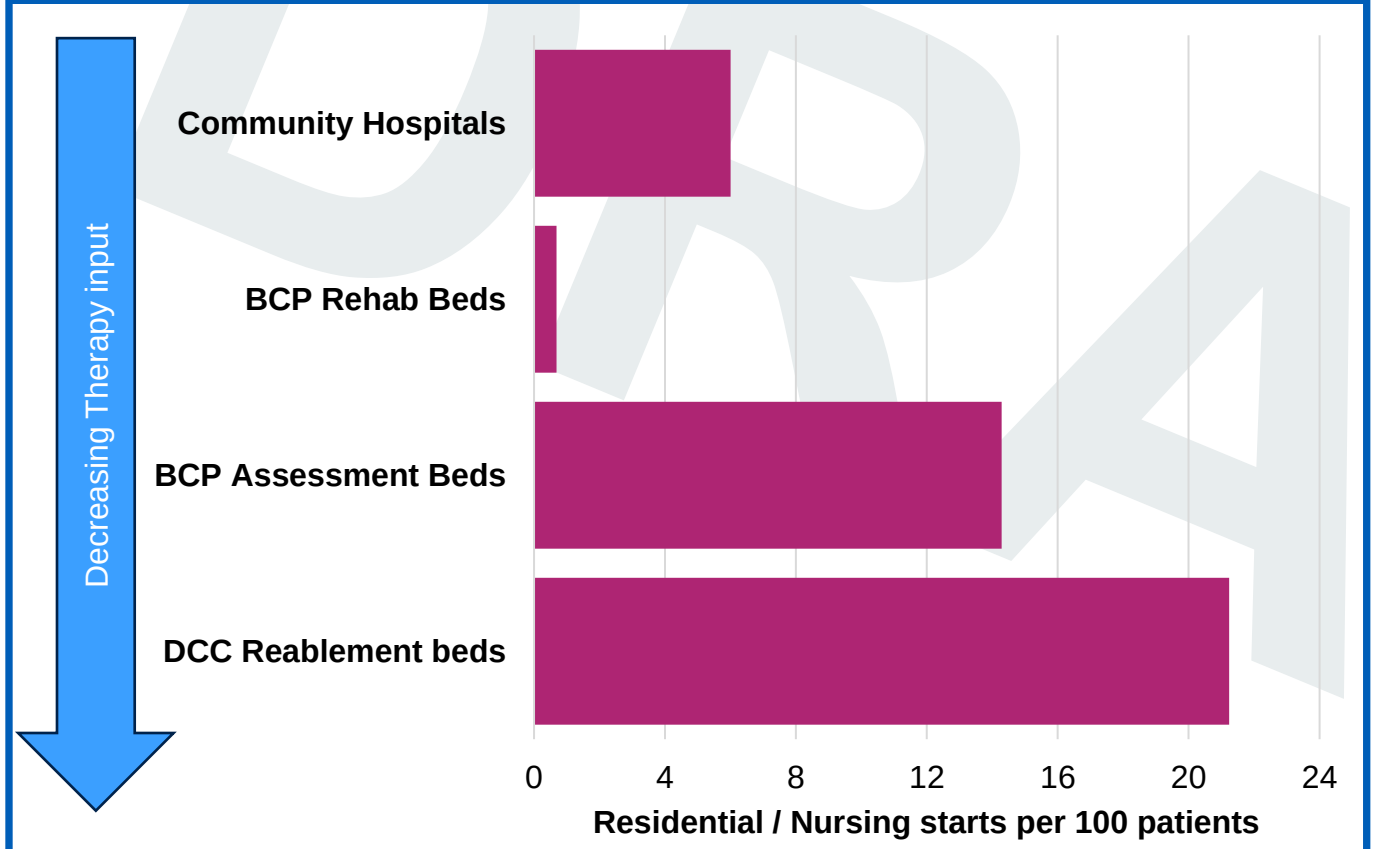
We have never really had consistent guidance on setting EDDs, we all do it our own way

Discharge Coordinator

*Data from DHC BI + studies of 79 CoHo beds across 3 sites (average of delays taken for non-studied sites)

There is significant variation in outcomes based on type of P2 bed accessed

Across all the sites in Dorset, patients are 2 to 3 times more likely to require long term Residential or Nursing care when they access P2 sites with off-site therapy input

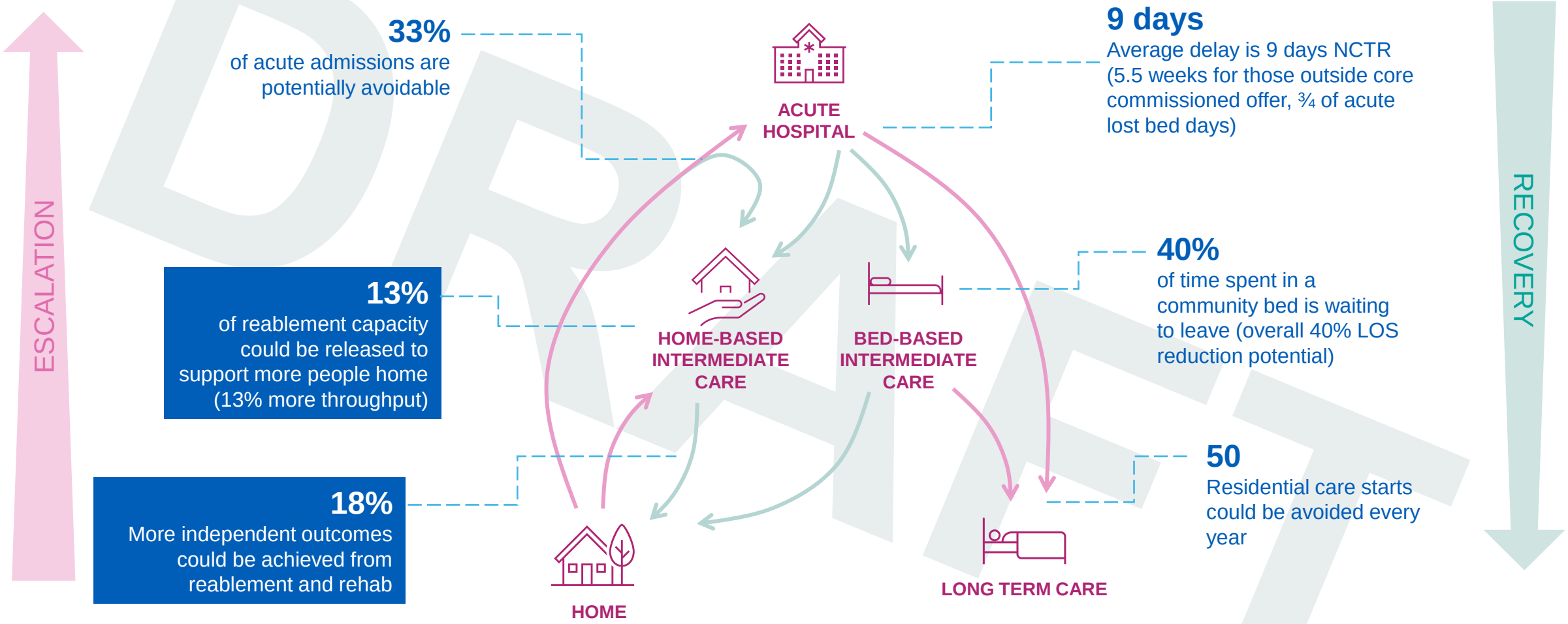


All of the types of pathway 2 site operate differently to best serve the needs of patients.

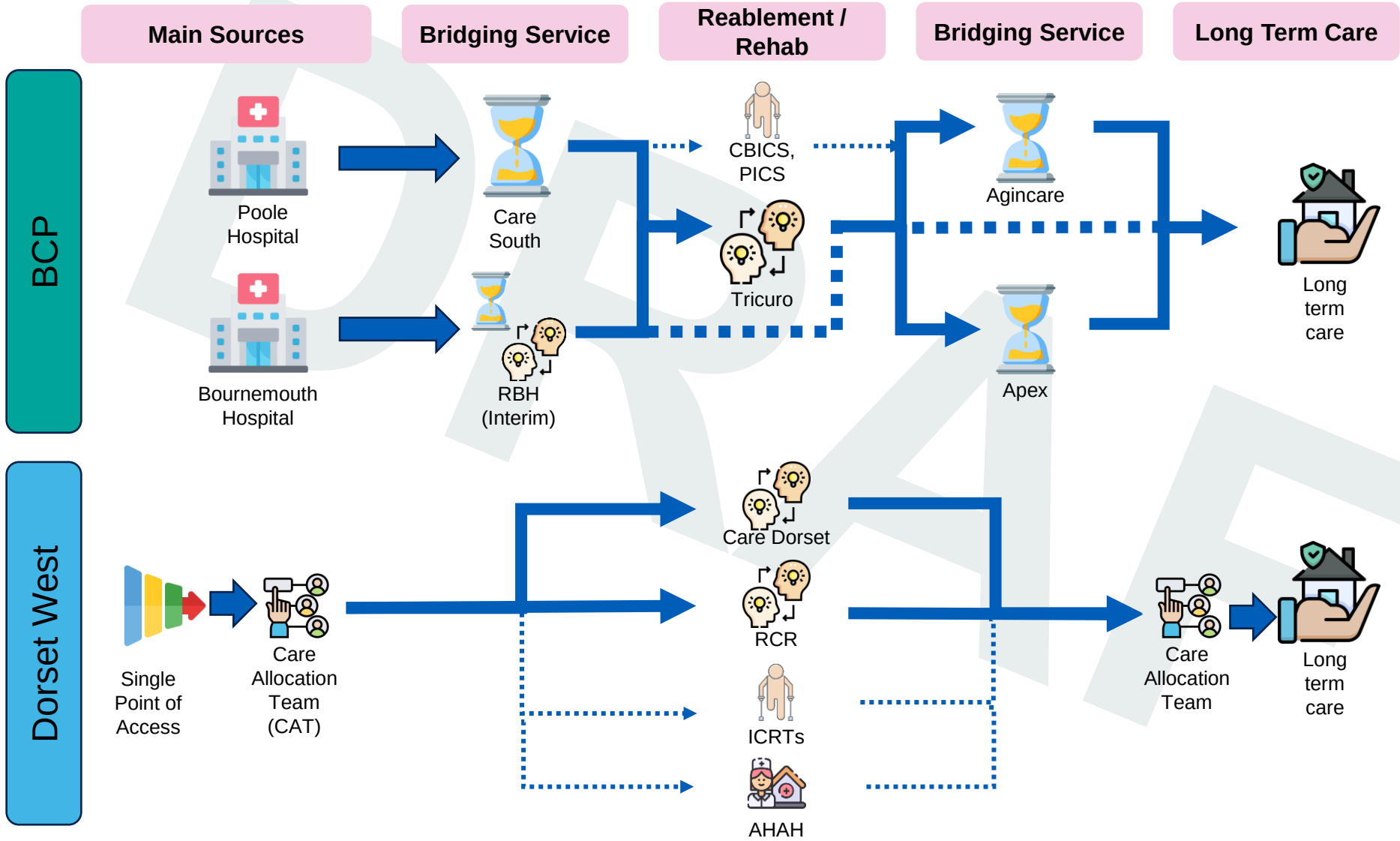
From observing processes through shadowing and applying best practice from other systems, we have highlighted 4 key enablers to improving outcomes across all beds:

MDTs	Using the combined experience of a multidisciplinary team, to plan the most effective actions to support their recovery.
Data Visibility	Ensuring the right people have access to key information about the patient
SMART Goals	Specific, Measurable, Achievable, Relevant and Time-based goals set consistent expectations of how to get each person home
Therapy Input	Managing therapist resource across sites to support patients as much as possible

The evidence shows an opportunity to improve outcomes for people, and to support financial sustainability, that we can't ignore



There are 32 different providers in pathway 1



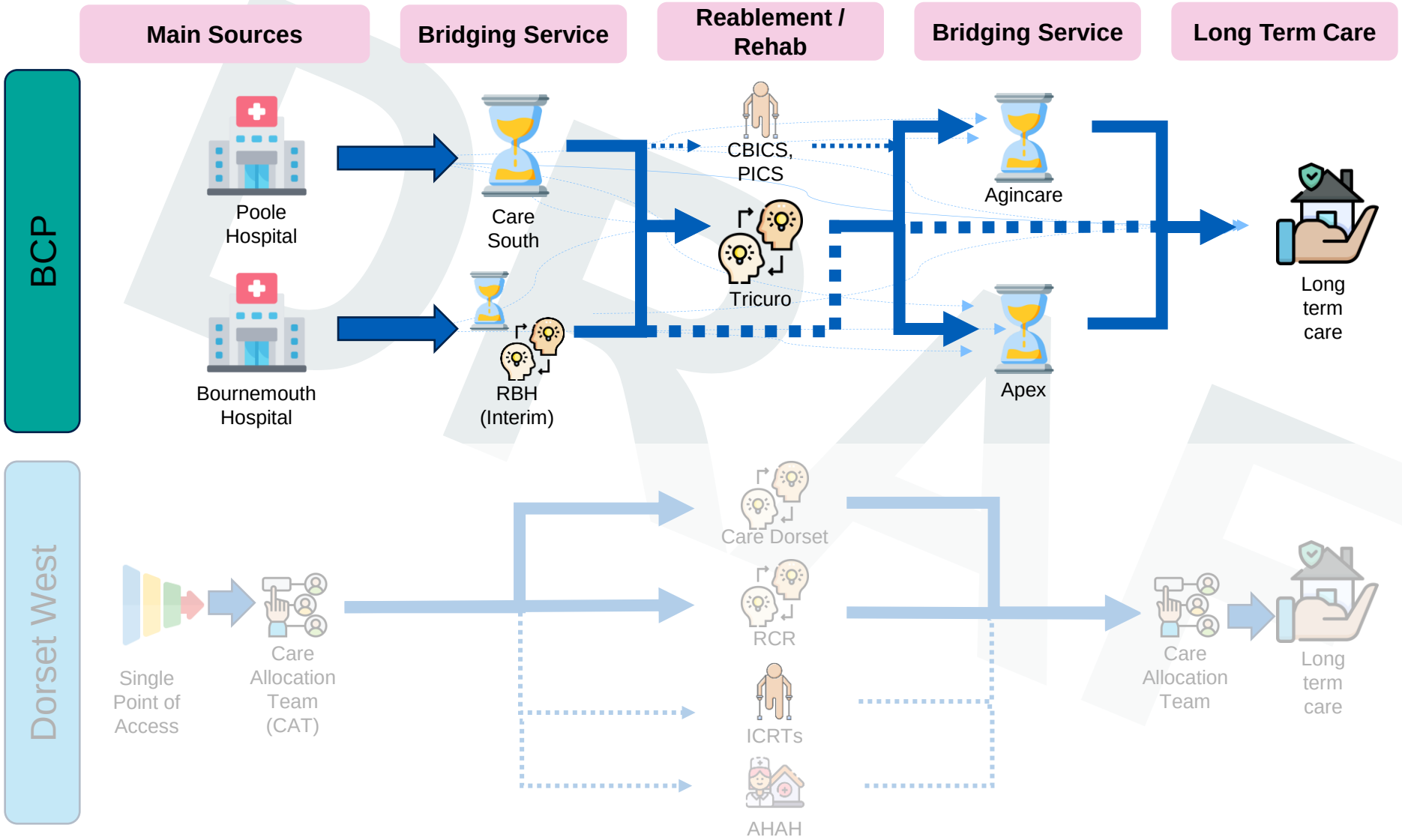
Of which, **most reablement** in Dorset occurs in **three providers**:

- Tricuro
- Care South
- Care Dorset

Illustrated are the **four main routes** into them:

- PGH -> Care South -> Tricuro
- BGH -> RBH (Interim) -> Tricuro
- CAT -> Care Dorset
- CAT -> RCR

The current process in BCP passes the person and their information through many separate services



There are **20+ different routes** a person could take.

People can **pass through 5 different services**.

At each **handover**:

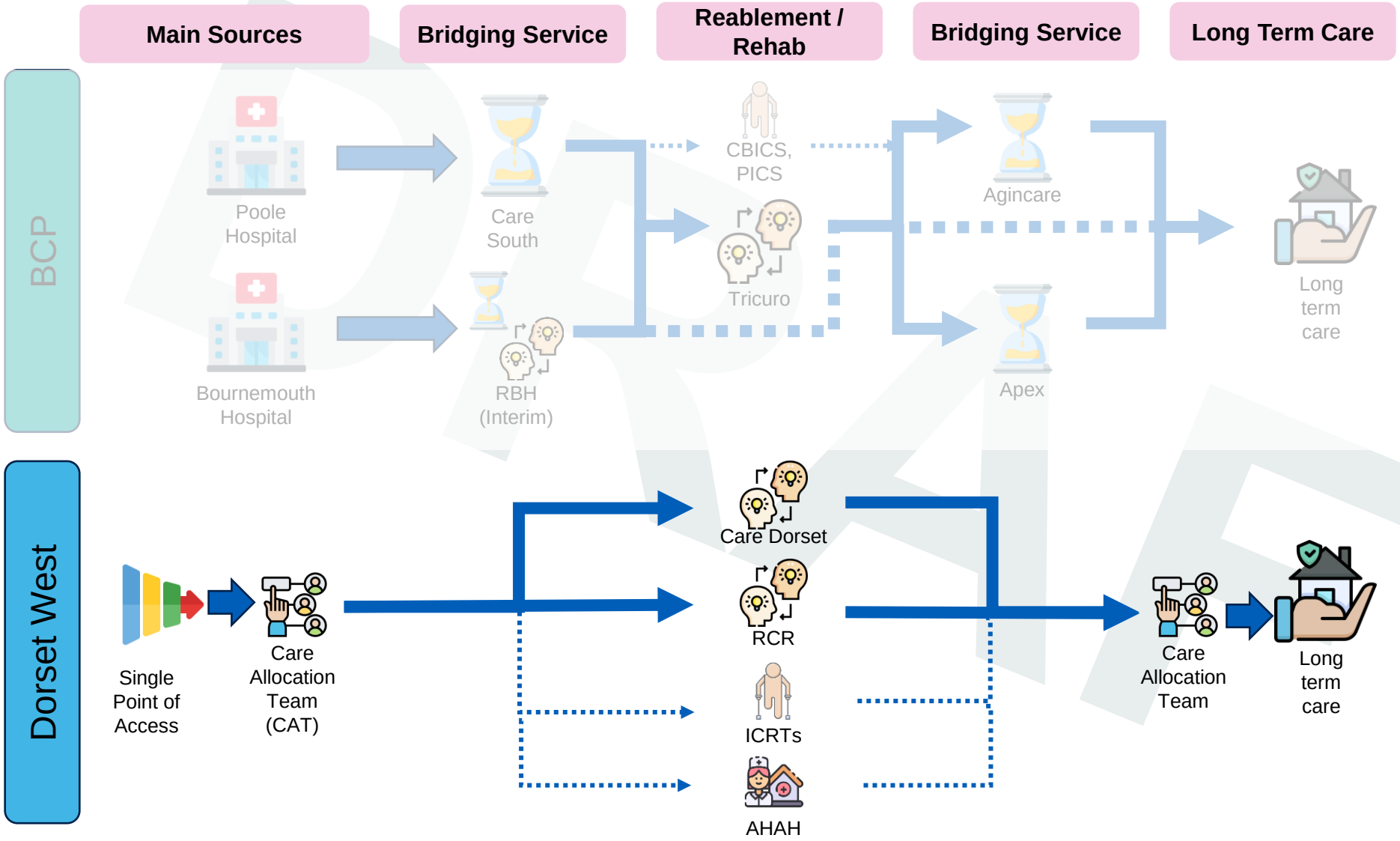
- The person must re-explain who they are and what they are trying to achieve.
- **Different** information and **goals** could be communicated to the person.
- **Information is lost** and time is required to understand the person.
- People's **needs are re-evaluated**.

"Social Work re-assess the hours decided by reablement and frequently increase them again".

Multiple providers can be involved with the same person at the same time.

Alongside a **confusing journey for both the person and staff**, this results in more time in intermediate care and reduced long term independence for the person.

The current process in Dorset West can create confusion with several providers competing for the same function



The **process is much clearer** in Dorset West.

An email goes out to all providers and the first to respond takes the person.

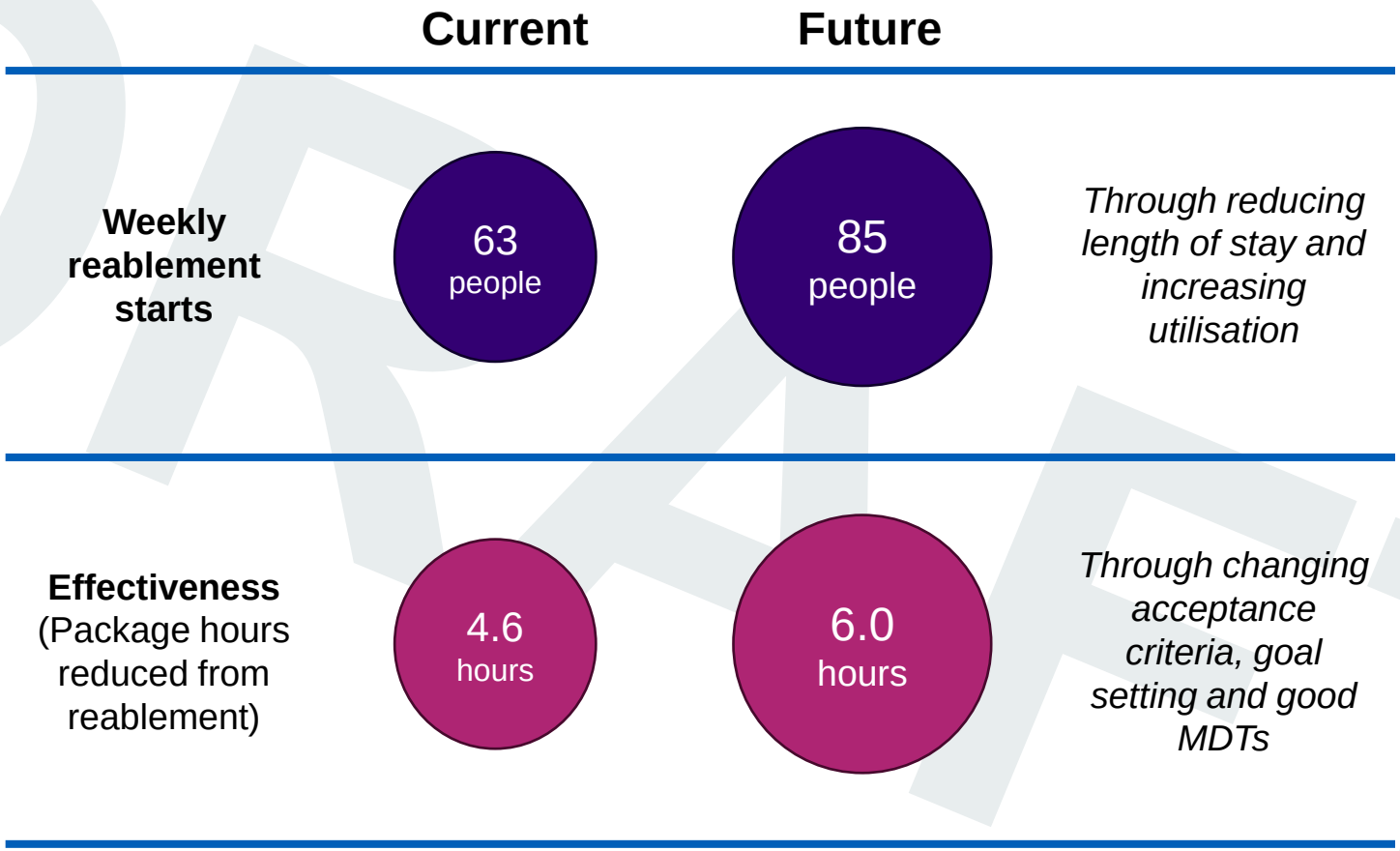
However, providers can feel like they are in competition with each other, resulting in worse collaboration.

Providers have the option to not pick people who would be more challenging to deliver care to; those in rural areas tend to stay on the waiting list for much longer.

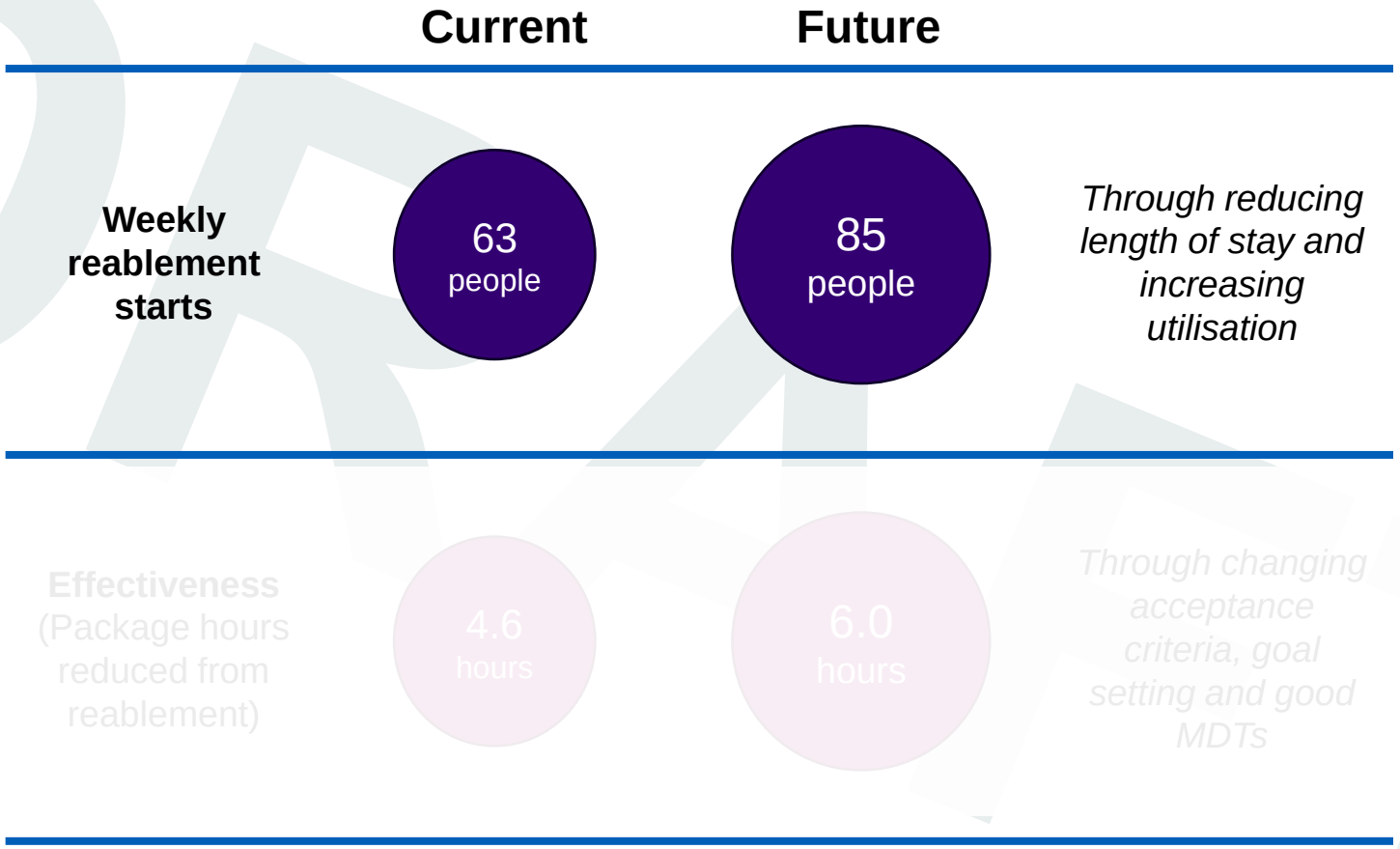
Despite having capacity at home, **83% of people in reablement beds could have gone home if the capacity was distributed correctly** to be able to take QDS and people in rural areas.

There is a lack of trust in the information
"Only 2 out of 10 referrals are accurate"

There is an opportunity to increase to number of people benefiting from reablement, and the effectiveness of the services



There is an opportunity to increase to number of people benefiting from reablement, and the effectiveness of the services



Is there unmet demand?

Out of 2000 people annually discharged onto pathway 2, **43% could have been supported at home**, improving their independence and happiness.

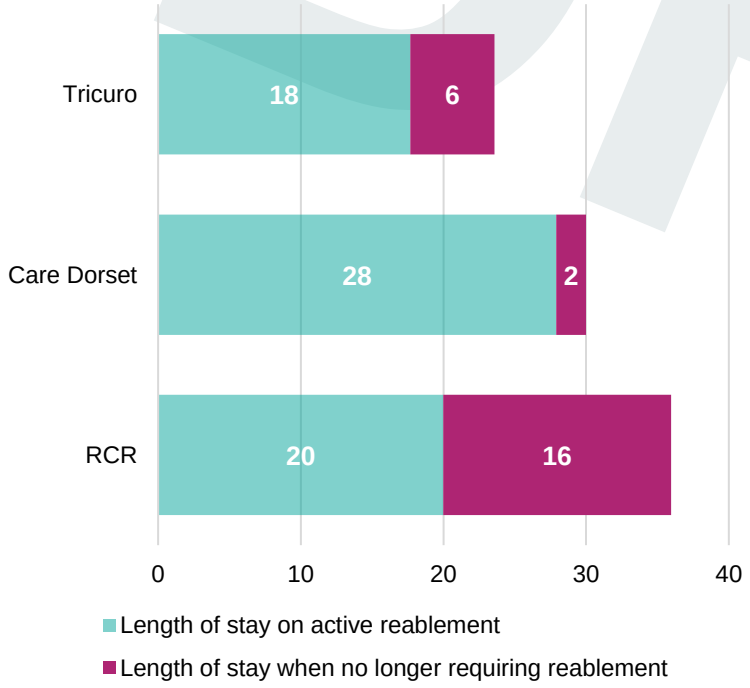
Increase of 7 starts per week in BCP, 12 starts per week in Dorset Council.

Do we have capacity to support this additional demand?

People are staying in a reablement services past when they have achieved their reablement potential

1 out of every 3 people in reablement are **no longer receiving active reablement**.

Length of stay whilst waiting for other services is too long



***Tricuro** databases show half of all people stay in the service beyond completing reaching their reablement potential. Of those who do:*

39%

Are self-funders

Self-funders believe they can stay with reablement for 6 weeks before they organise their own long-term care. This means they often stay in the service for much longer than their reablement need.

23%

Are waiting for a package of care to be sourced

We are not planning for exits early, this means communication with the person and ongoing services only starts when someone is at or near the end of their reablement journey.

Most people exit Care Dorset without delay

Very few people go on maintenance but for those who do, maintenance accounts for 40% of their overall length of stay. These are often more complex cases, which providers are resistant to take on due to behaviour/history, care needs which are too great or how remote they are.

In RCR and RBH (Interim), there are a spread of reasons why people stay in the service while not actively being re-abled:

Waiting for Equipment from Hospital

Too unwell from reablement

Waiting for social work involvement

Waiting for an ongoing package of care

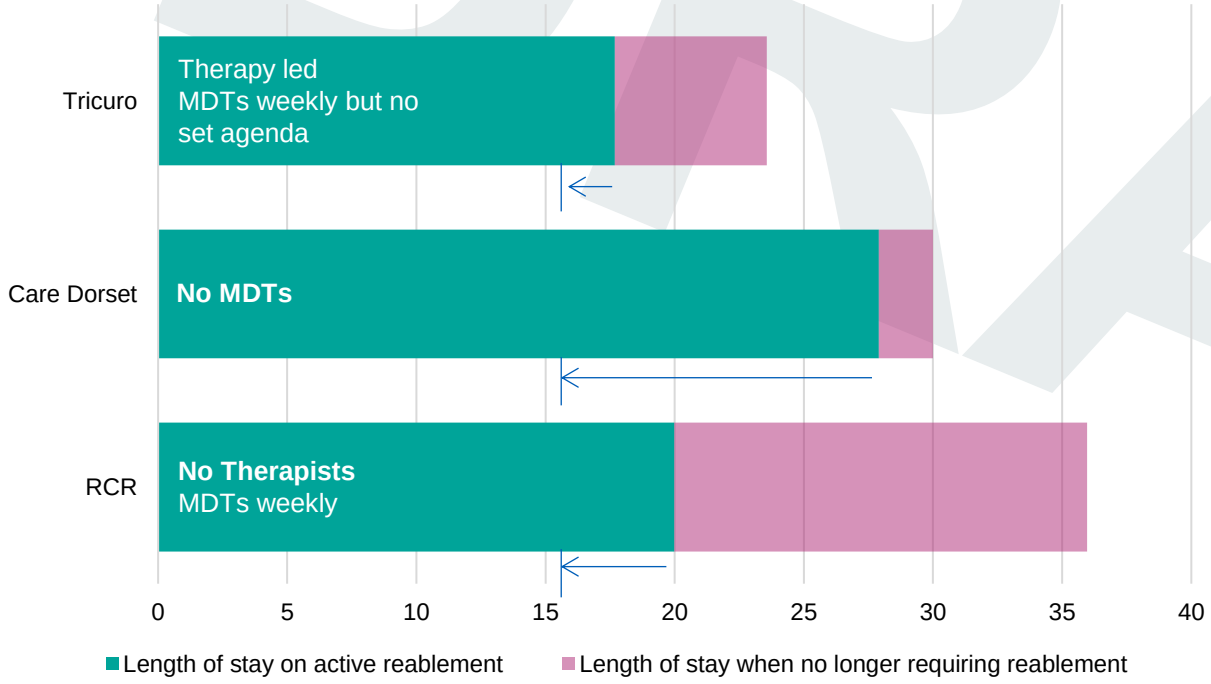
Total length of stay from providers and split of active reablement time from studies

Better goals management would support an improvement in active reablement time

To ensure strong effectiveness of home-based care, it is essential that the right professionals are able to input at the right time. A key enabler of this is MDTs and therapy interventions.

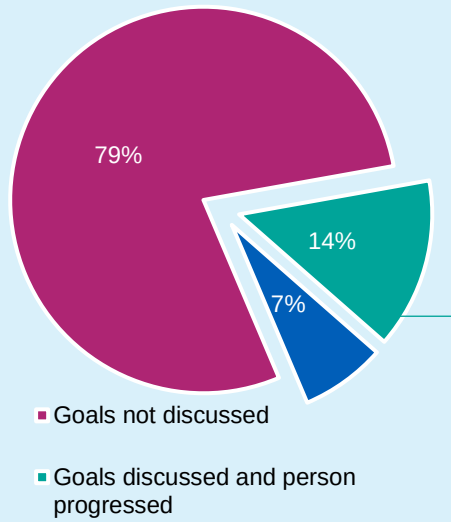
For people with **goals accurately tracked**, the active reablement **length of stay** has been seen to reduce to **16 days**

Length of stay whilst actively receiving reablement is too long



Tricuro has all the elements to deliver strong outcomes and has the shortest active reablement time but **MDTs could be used more effectively to improve outcomes**

In Tricuro, only 21% of people had goals mentioned in the MDT



Of that 21%, the **MDT supported progress in 2/3 of cases** – emphasising there is already evidence showing **when goals are tracked in MDTs it does help improve progress**

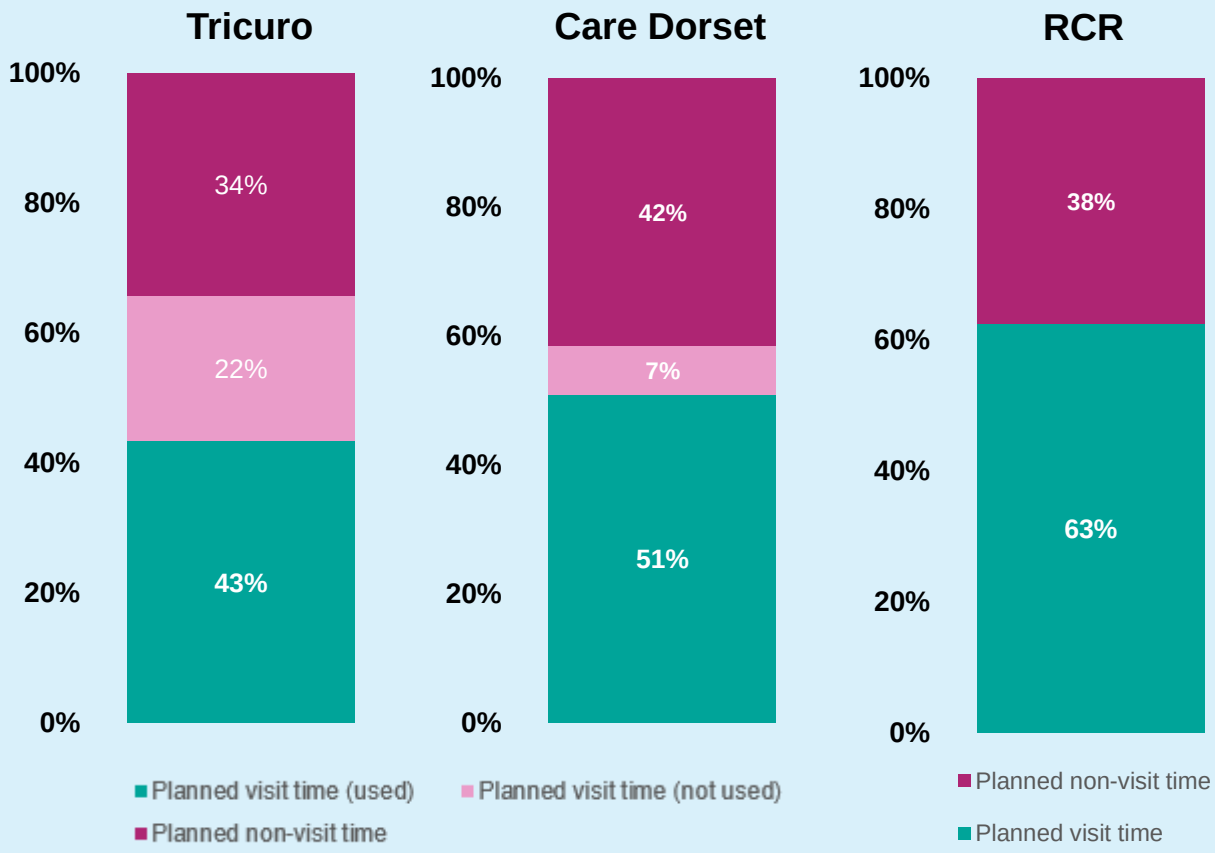
In ***RCR*** MDTs, conversations support next steps, and which services were involved in progressing those, **however reablement goals and progression on goals are not discussed for any patient**.

Total length of stay from providers. Split of active reablement time and MDT information from studies

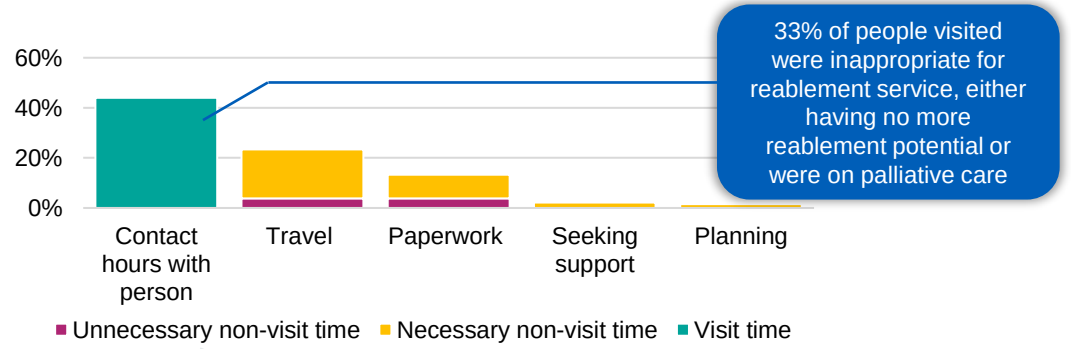
Reablement workers* could visit more people each day

Reablement workers could spend more of their time with service users by better planning how long visits should be, optimising routes and have consistent and balanced rotas.

Increasing utilisation by 10% would enable 9 more starts per week



In Tricuro, less than half of reablment workers' time was spent with the person

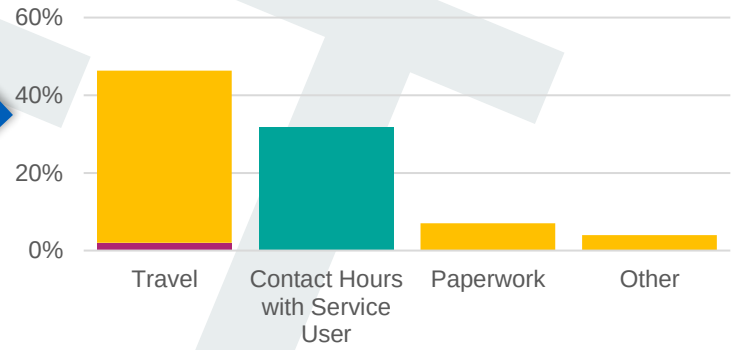


33% of people visited were inappropriate for reablement service, either having no more reablement potential or were on palliative care

Travel distances are further between visits for Care Dorset than Tricuro – but often aren't optimised

"When travel time is calculated on Access, the scheduling system, it uses google maps estimates at the time of programming, not the time of visit, often underestimating how long it will take or the best route at that time"

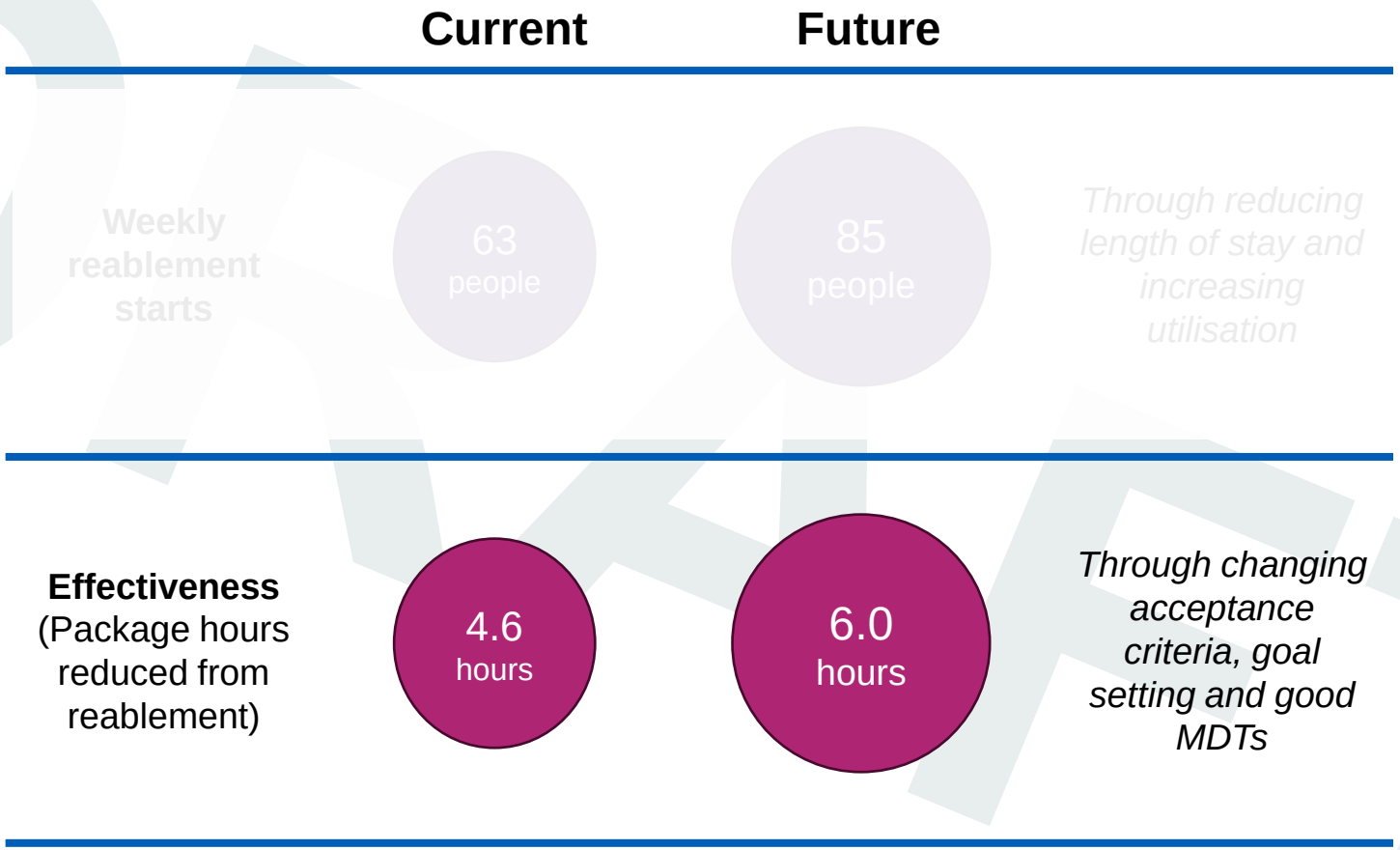
In Care Dorset, Travel accounted for 46% of the reablement workers' shift



*Reablement workers are also referred to as Community Therapy Assistants and carers

Planned visit time from providers, all other data from studies

There is an opportunity to increase to number of people benefiting from reablement, and the effectiveness of the services



People could leave reablement with more independence

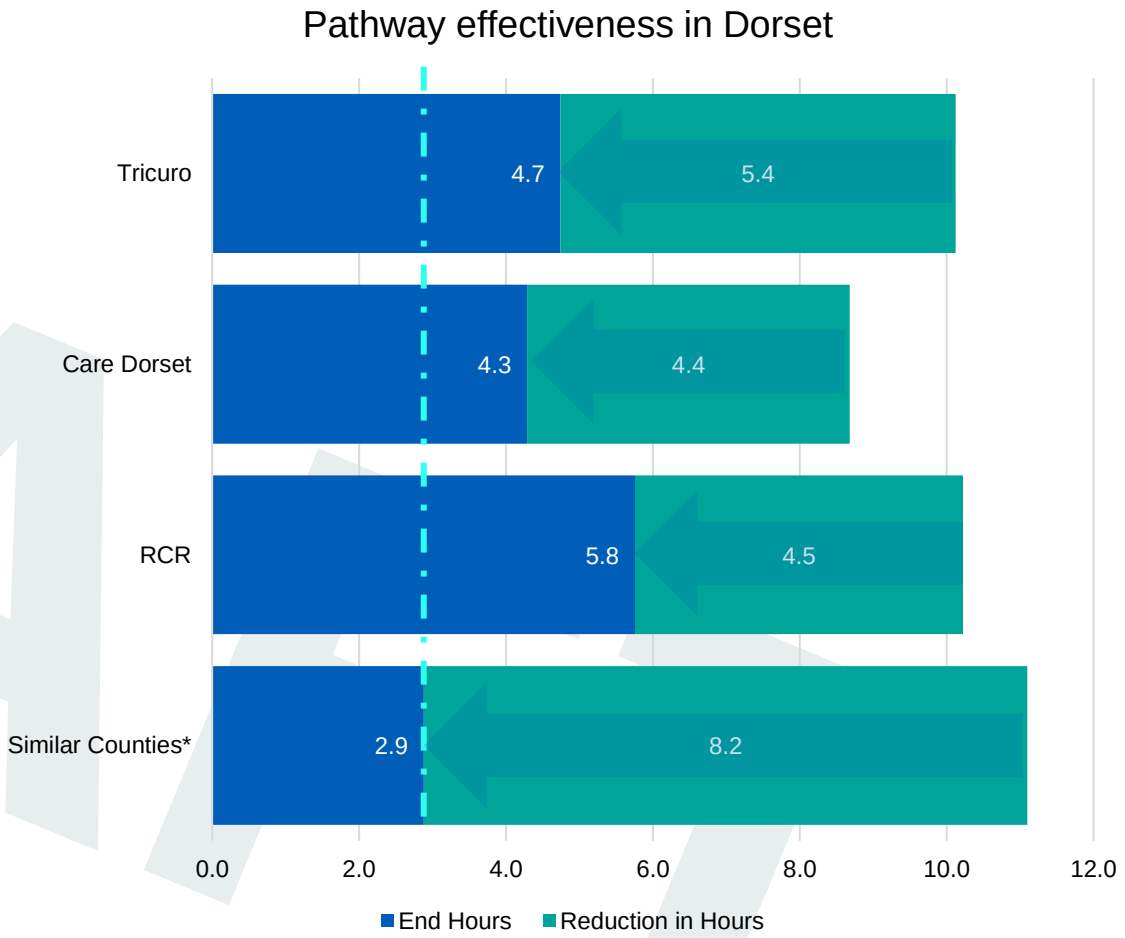
The primary focus of a reablement service is to take anyone who could be at home and support them to their maximum independence.

Dorset could take people with higher needs into reablement, with Tricuro and Care Dorset not taking those who need double handed care.

A strong performing system will achieve a home-based intermediate care effectiveness upwards of 8.2 hours (8.2-hour reduction between start and end of package) but

Dorset currently has a pathway effectiveness of 4.7 hours per week

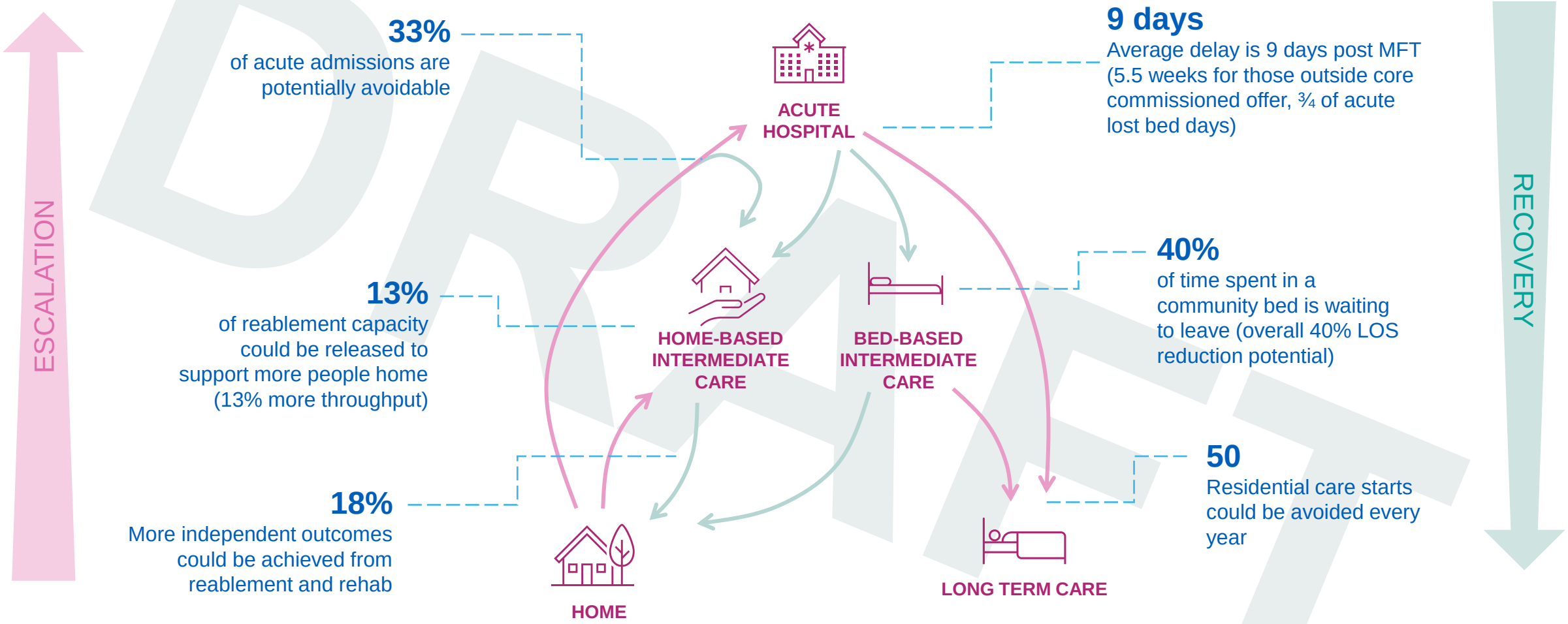
When comparing Dorset to similar systems of Essex, Cumbria and Leicestershire, Dorset's pathway is 43% less effective in reabling people



* Leicestershire, Cumbria and Essex have been used as similar examples of widespread areas with varying deprivation

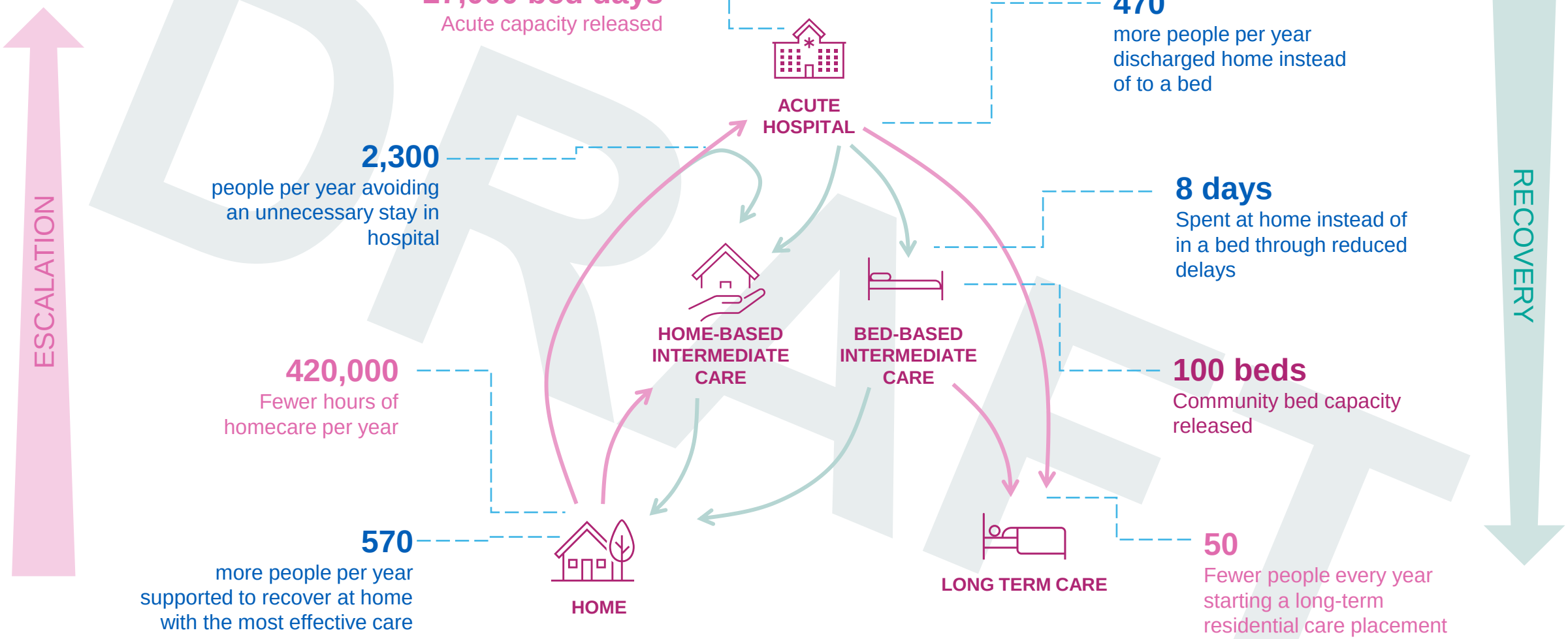
Data provided by Tricuro, Care Dorset and RCR, compared against Newton records

The evidence shows an opportunity to improve outcomes for people, and to support financial sustainability, that we can't ignore



What impact would these opportunities have **for people?**

What impact would these opportunities have **for the system?**



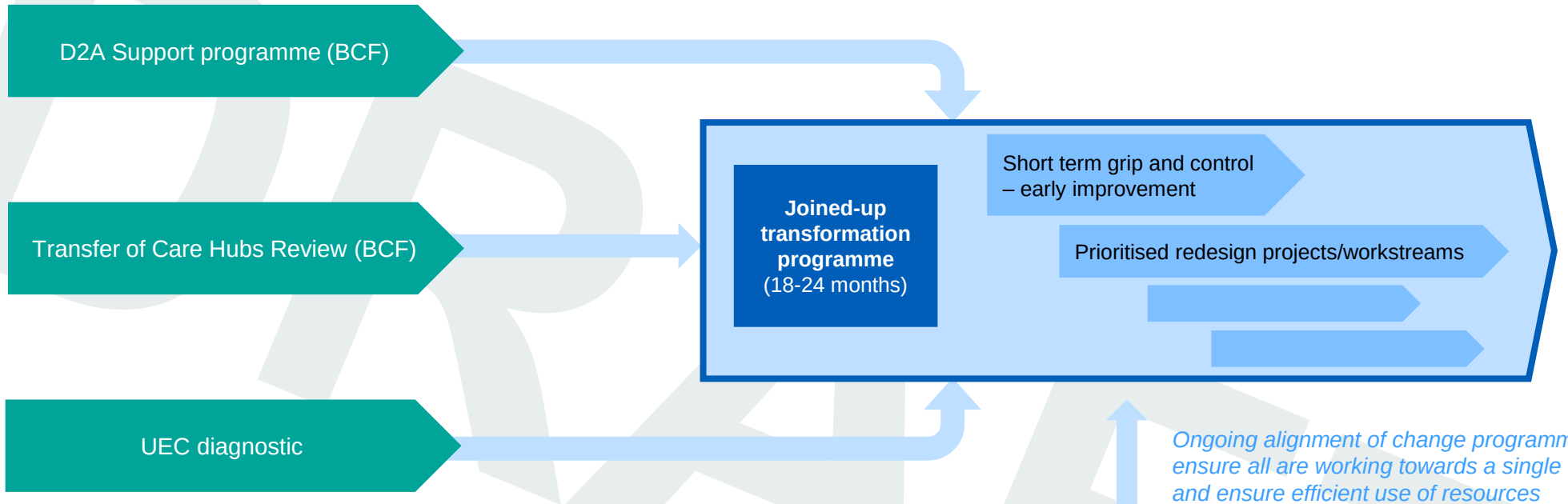
Financial Opportunity Matrix

DRAFT
values to be validated with finance teams
and final analysis may change values

Area	Opportunity	Operational impact	Total financial opportunity
Home-based Intermediate Care	Reablement Throughput	**184k reduced care hours**	£ 5.8m
	Reablement Effectiveness	**231k reduced care hours**	
	Reablement Overlap	**6k reduced care hours**	
Bed Based Intermediate Care	Rehab & Recovery Length of Stay	**8.4 days reduced Length of stay**	£ 4.0m
	Rehab & Recovery Outcomes (Residential & Nursing Placement Avoidance)	**8.8 fewer resi starts**	
Flow and Discharge	Hospital NR2R Length of Stay	**1.8 days reduced Length of stay**	£ 10.0m
	Discharge Outcomes (Residential & Nursing Placement Avoidance)	**43.7 fewer resi starts**	
	Pathway 2 Reduction	**468 fewer community bed starts**	
Admission Avoidance	Virtual Ward Starts	**780 avoided admissions**	£ 5.3m
	SDEC Activity	**1500 avoided admissions**	
		Programme Total:	**£ 25.0m**

Implementation planning

We have an opportunity to bring together existing work across the system to ensure a joined-up implementation



Ongoing alignment of change programmes to ensure all are working towards a single vision and ensure efficient use of resources

Ongoing change programmes with interdependencies

Much work is already happening to address the challenges. This programme will build on and join up existing work, delivering alongside key programmes of change.

- Intermediate Care Review
- Integrated Neighbourhood Teams
- Dorset Council ASC op model redesign
- BCP transformation Programme

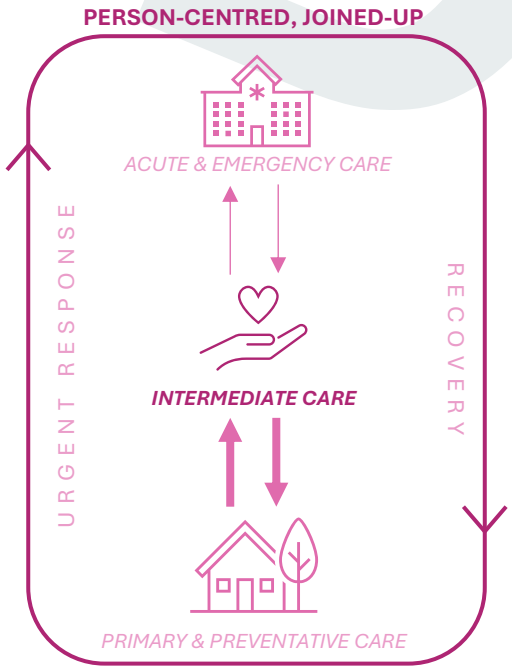
The Programme Vision

Our ICS has set a vision for Dorset:

Dorset's integrated care system works together to deliver the best possible improvements in health and wellbeing

For this programme, that means:

A sustainable, person-centred model of urgent and intermediate care across Dorset that is joined-up and promotes recovery and independence



Example programme name:

Evolve

Working together to transform intermediate care

*What does this mean **for people?***

- Patients, service users and carers can have better, more independent, health and care outcomes
- Reduce harm that our system can cause
- Simple services, with a joined-up and caring experience for the person, where they are involved in their care at every step

*What does this mean **for staff?***

- Reduce frustration of delays and lack of capacity
- Simpler, person-focused processes and pathways
- Improved tools and systems

*What does this mean **for the system?***

- Simplify our current fragmented offer
- Support system flow and reduce pressure
- More financially sustainable

Programme Objectives

The programme will develop and implement new models and ways of working for intermediate care services and transfer of care functions for people being discharged from hospital or at risk of admission to hospital. In achieving the vision, our objectives are:

Achieve more **independent and safe** outcomes

Enable more people to **stay at home** and out of hospital

Improve the **experience** for the person, carers and staff

Reduce **delays** through the urgent and emergency care system

Ensure the urgent and intermediate care offer provides **best value** for the system

Programme Scope

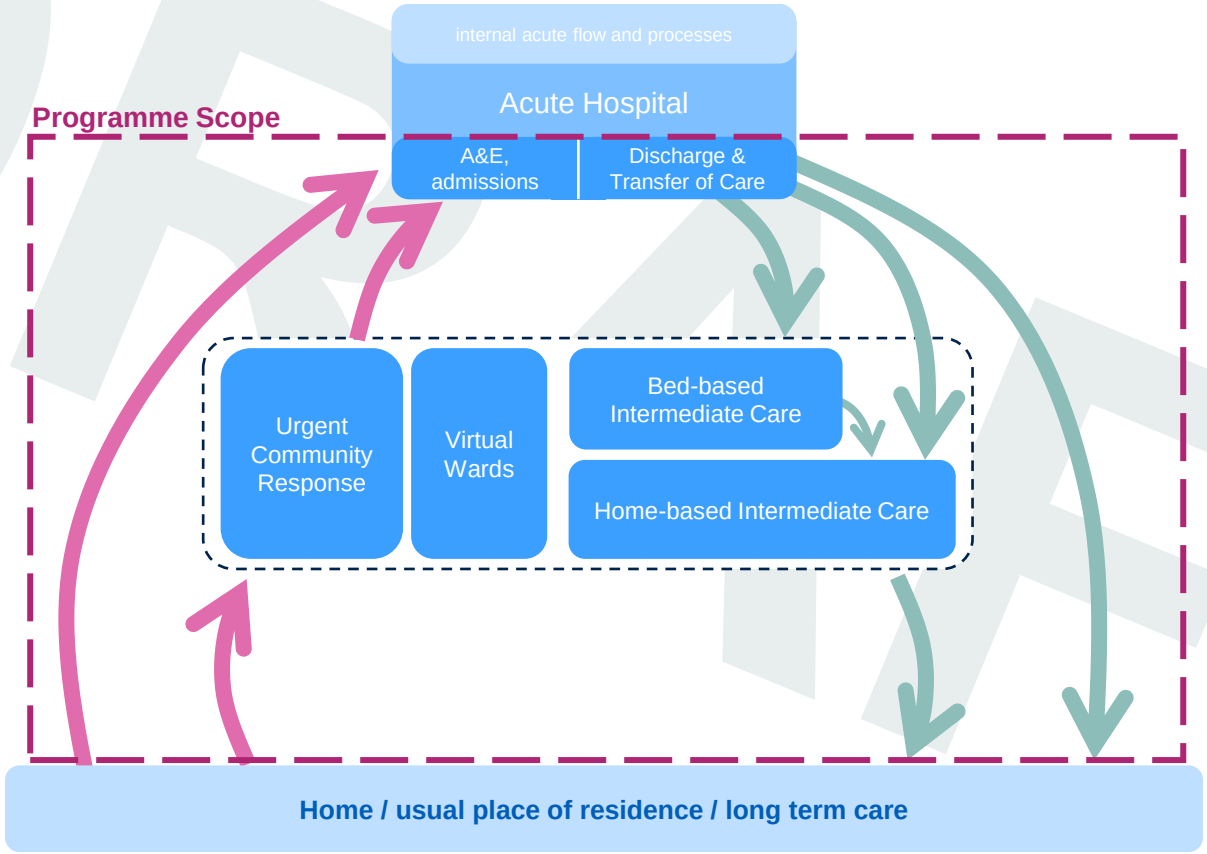
To achieve the benefits identified in the diagnostic, improving system flow and long-term outcomes, the scope of the programme must include the intermediate care service delivery, **and** the interfaces with, and processes in, the rest of the system that influence the referrals to intermediate care, and the out-flow and outcomes from intermediate care.

Therefore, the scope covers the teams and services involved in hospital admissions, hospital discharges, intermediate care capacity and outcomes (step-up and step-down, home-based and bed-based, health and social care), discharge from intermediate care and the interfaces to long-term care

EMERGENCY & ACUTE CARE

INTERMEDIATE CARE

PRIMARY & PREVENTIVE CARE



Not directly in scope (not transforming these services) but essential dependencies and must be part of co-design:

- Mental health services
- VCS
- Integrated Neighbourhood Teams
- Ambulance Service (SWAST)
- Primary Care
- Urgent Care (UTCs, walk-in centres)
- Public Health

A programme led by outcomes

An important principle is that the scope and focus of the programme will be led by the outcomes and performance improvements we are aiming for across the system, not by individual services, teams or specific target models.

Defined performance measures that are based on a better experience and outcome for the person, agnostic of organisation, will be at the heart of the programme.

What outcomes do we want to achieve for people?

➢ *What are the measures of a high performing UEC/intermediate care system?*

Support people in the community to avoid hospital where possible
- ➢ *Referrals to IC to avoid admission (demand)*
- ➢ *Activity in admission avoidance services (capacity)*

Minimise delays for people leaving hospital
- ➢ *NR2R length of stay*

Most independent discharge pathway decision
- ➢ *% discharges P0, P1, P2, P3*

Time in community bed is active recovery to regain independence where possible, not waiting for onward care
- ➢ *Short-term bed LoS*
- ➢ *% of discharges to home*

Everyone who can benefit from effective home-based recovery has the opportunity to do so
- ➢ *Number of finishers per week from reablement/recovery offer*

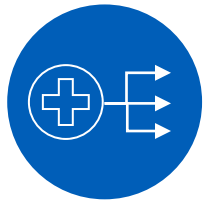
Most independent long-term care outcome from intermediate care
- ➢ *Effectiveness of home-based IC (starting need vs. end need)*

The programme should be structured across 6 delivery projects

INTERFACES

Admission Avoidance

Front door decision making
Access and capacity of community response offers



Transfers of Care

Discharge planning and decision making
Process and flow leaving acute and intermediate services

COMMUNITY PROVISION

Home-based intermediate care

Capacity and flow through reablement and rehab
Effectiveness and outcomes

Bed-based intermediate care

Capacity and flow through all short-term beds
Effectiveness and outcomes

CORE ENABLERS

System Visibility & Active System Leadership

Trusted single point of truth with live data
Data-driven decision making and leadership embedded at every level

Change Capability Development

Programme name Academy development programme to build change capability across staff
Behavioural and cultural change for true sustainability of change at scale

How will the programme be delivered?

Focus on people, capability development, culture change and co-production

- Building staff capability from the start of the Programme to shift the culture further towards a transformational and empowered mindset.
- Working shoulder-to-shoulder with the System to co-produce the change we need to achieve the vision we've set out
- Continuous leadership support to embed Systems Thinking throughout the Programme and provide the right resources for leaders to drive change within their organisations

Truly a partnership programme, aligned around a shared vision

- Commitment to strategic programmes alongside short-term pressures
- Willing to deprioritise where needed – lots of siloed programmes in parallel has not delivered the result
- Focus resources and efforts on biggest impacts for outcomes

Led by outcomes for people, not organisational priorities

- The person being at the heart of everything we do refocuses the decisions we need to make as a System from board to ward.
- Maintaining a spotlight throughout the Programme on the Voice of the Person and the impact we're having on the Dorset community

Data-led change, focused on evidence, not anecdote

- Push for a single point of truth – trusted and accessible
- Measure live performance linked to outcomes
- Actionable data that drives behaviour change, not just reports
- Rigorous tracking of operational impact and link to finances

Transformation capacity and expertise

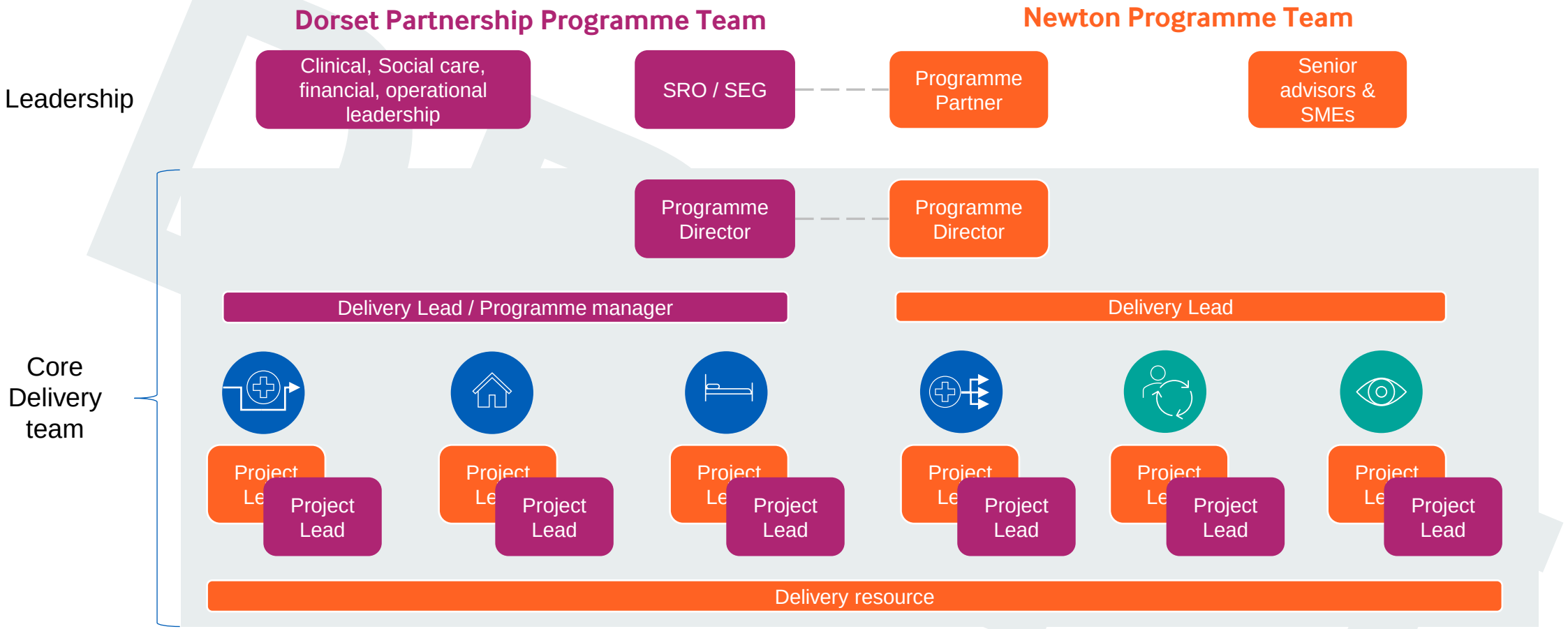
- Dedicated transformation resource from partners to see it through

How will the programme be delivered?

An approach to system-wide transformation with a track record of delivering improved outcomes and measurable benefits

How will the programme be delivered?

A **joint delivery team** will be an essential part of the programme



- Full time roles seconded or recruited, ideally with Dorset knowledge
- Mirrored team of Dorset staff and Partner resource at every level
- True co-production of change with the System
- Culture of shared objectives – commercially and structurally setup to deliver the best outcomes for people and the system
- Core team given extensive training through the Academy model and on-the-job

What is the Academy?

A full-suite of tailored development courses designed to enable Connect Leaders to design, implement and sustain impactful change.

Why do we need the Academy?

Ensure we are all speaking the same language in our collective drive towards **better outcomes** for the people of Dorset

Build capabilities in a core set of skills critical for successfully **delivering change**

Foster a highly effective collaborative network of leaders, with a **strong sense of belonging** and mutual understanding

Establish a **strong legacy** of best-in-class change management skills and a track record of positive change

Two routes, for core team and for leaders

The Academy

What: 2-week training course, followed by ongoing period of structured development.

Who: Core delivery team responsible for on-the-ground delivery.

How: In person 'classroom' sessions

Academy-lite

What: Targeted ½ day sessions on The Academy essentials.

Who: leaders Wider group of colleagues and involved in the Programme, split into two strands

How: Virtual / in-person

Example modules

Problem Solving

Improvement methodologies, problem solving framework, bottom-up and top-down analysis, process mapping and process improvement

Essential Skills

Functional data analysis essentials, effective presentation masterclass

People

Culture and resistance, stakeholder management, high performing teams and motivation

Programme and Change Mgmt.

Change management, the change curve, KPIs and the improvement cycle, programme management and project planning

Management and Development

Giving and receiving feedback, effective meetings, delegation and performance management

Decision Making

Co-creating a structure across leadership on how we'll agree to make System decisions

The tension between short-term pressure and transformation requires a phased approach without delaying our long-term aim